

Patient-Physician Communication

MR Asnani

*“It is much more important to know what sort of patient has the disease than what sort of disease a patient has.”
Sir William Osler*

“The purpose of the doctor:

- To cure sometimes*
 - To relieve often*
 - To comfort always”*
- Socrates*

ABSTRACT

Extensive research has shown that no matter how knowledgeable the physician might be, if he/she is not able to open good communication channels with the patient, he/she may be of no help to the latter. Despite this known fact and the fact that a patient-physician consultation is the most widely performed ‘procedure’ in a physician’s professional lifetime, effective communication with the patient has been found to be sadly lacking. This review article seeks to discuss ‘the what, ‘the why’ and ‘the how’ of doctor-patient communication.

La Comunicación Paciente-Médico

MR Asnani

*“Es mucho más importante saber que clase de paciente tiene la enfermedad, que saber que clase de enfermedad tiene el paciente.”
Sir William Osler*

“El propósito del doctor:

- Curar algunas veces*
 - Aliviar a menudo*
 - Confortar siempre”*
- Sócrates*

RESUMEN

Las investigaciones han demostrado abundantemente que no importa cuán profundos sean los conocimientos del médico, si no puede abrir un buen canal de comunicación con el paciente, no podrá ser de ayuda alguna a este último. A pesar de este hecho conocido y el hecho que una consulta paciente-médico es el ‘procedimiento’ más ampliamente realizado a través de la vida profesional de un médico, se ha hallado que lamentablemente falta una comunicación efectiva con el paciente. Este artículo examina discutir “el qué”, “el por qué” y “el cómo” de comunicación doctor-paciente.

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INTRODUCTION

Communication can be defined as specific tasks and observable behaviours that include interviewing to obtain a medical history as well as a patient's reason for the visit, discussing a diagnosis and prognosis, giving instructions on therapy and information needed for informed consent before undergoing any procedures, and counselling to motivate participation in treatment or to relieve symptoms (1). It is a series of learned skills, a set of procedures for improving outcomes of care. Traditionally, communication skills were not a part of the formal medical curricula but were incorporated informally during ward rounds and supervisor feedback. There were inconsistencies in these methods and so these skills are being increasingly taught more formally. There is no doubt that communication skills may be more inherent in some types of personalities, however, anyone who wants to learn can easily learn such skills (2, 3).

The Problem

Doctor-patient communication is a basic clinical skill, as basic a skill as medical technical knowledge, physical examination and medical problem-solving. Even though a communicative provider-patient relationship is especially important in the management of chronic diseases, such as diabetes mellitus, hypertension, coronary artery disease and congestive heart failure, it is a skill that all clinicians require. An average physician may perform 120 000 – 150 000 patient consultations over a 40-year professional career (4), making it the most frequent 'procedure' performed in his/her practice. Despite these facts, the patient-physician communication has often times been found to be inadequate. McBride *et al* reported that patients considered 'physician communication skills' to be one of the most important physician competencies (5). They also rated it to be one of the 'poorest' skills in their physicians. Whereas there may be ongoing advances in technical skills in medicine, communication skills have been found to be deteriorating (6). Cegala *et al* (7) determined in their study that even though there was considerable agreement between physicians and patients on the categories of competent patient communication, there was little agreement as to whether competent communication had occurred. This may of course be due to the fact that physicians and patients have different views of what constitutes good communication.

Determining a patient's reasons for seeking care is of critical importance in any medical encounter. However, Beckman *et al* (8) showed that only in 23% of the times were patients given an opportunity to complete their opening statements of concern. Marvel *et al* (9) similarly showed that physicians redirected the patient's opening statement after a mean of 23.1 seconds. It was also shown, that if patients were allowed to complete their statement of concerns, they used only six seconds more on average than those who were redirected before completion of concerns. A qualitative study conducted in south-east England (10) found that only four of

35 patients had voiced all their agenda items during the consultation. It was shown also that agenda items that were not raised in the consultation often led to specific problem outcomes, for example, major misunderstandings, unwanted prescriptions, non-use of prescriptions and non-adherence to treatment. Sutcliffe *et al* (11) have shown that the occurrence of everyday medical mishaps is associated with faulty communication. Furthermore, Levinson and colleagues (12) studied physicians involved in malpractice claims and identified significant differences in communication behaviours of no-claims and claims physicians. They showed that compared with claims primary care physicians, no-claims primary care physicians used more statements of orientation (educating patients about what to expect and the flow of a visit), laughed and used humour more, and tended to use more facilitation (soliciting patients' opinions, checking understanding and encouraging patients to talk). No-claims primary care physicians spent longer in routine visits than claims primary care physicians (mean, 18.3 *versus* 15.0 minutes) and the length of the visit had an independent effect in predicting claims status. The decision to litigate has been shown to be often associated with a perceived lack of caring and/or collaboration in the delivery of healthcare (13). Perceived unavailability, discounting patient and/or family concerns, poor delivery of information and lack of understanding of the patient and/or family perspective have been identified as problem issues (14).

Levinson *et al* (15) have also shown in work with surgeons, that on average, more than 90% of the content utterances pertained directly to the patients' medical conditions or therapies. This included asking questions and giving information by both physicians and patients and physicians counselling patients about medical conditions or therapies. Less than 10% of the content of communication was devoted to lifestyle issues (*eg*, how the patient's work was affected by the clinical problem or surgery) and psychosocial issues (*eg*, the patient's emotions or general state of mind). Patients were more likely to discuss both lifestyle concerns (mean 5.3 patient utterances per visit, mean 2.9 surgeon utterances per visit) and psychosocial issues than surgeons were (mean 2.8 patient utterances per visit, mean 0.03 surgeon utterances per visit). The latter of course shows that psychosocial issues are important to the patients; patients are more satisfied when physicians explore illness in the context of the patient's life, understanding the broad concerns of the patient, not just the patient's disease (16 – 18). This is true whether the visit is for primary care, surgical opinion, paediatric care or orthopaedic care *etc*.

Studies have found that oncologists consistently perceived cancer patients' distress to be lower than patients' self-reported distress levels (19, 20). Despite the fact that consultations concerning life-threatening disease often contain information regarding toxic treatment which is known to provoke psychological dysfunction, the number of questions relating to patients' psychological health have been shown to

be few (21). In this study, patients were well informed about their diagnosis, prognosis and treatment options, but their emotional well-being was rarely probed.

Why Communicate?

In today's fast-paced medical world, relationship-building consultations among physicians and patients can get lost. The demands to keep abreast of and to utilize the most current technologies in managing patients can easily overshadow the need to communicate effectively. Yet, positive physician-patient relationships are a critical part of the healing process (22). A physician has the perfect opportunity to develop a relationship with the patient during the initial clinical encounter, and the quality of this relationship influences the flow of further dialogue that leads to a harmony of understanding so necessary for successful medical therapeutics (23). Although concerns are often raised that practice conditions may not allow clinicians the time to give attention to these issues, clear evidence indicates that interviews that attend to patients' feelings, ideas and values actually save time (9, 24).

Good communication is in fact good business practice and leads to greater patient satisfaction, improved clinical outcomes and increased patient compliance (15, 25). Patient-perceived physician empathy is shown to significantly influence patient satisfaction and compliance *via* the mediating factors of information exchange, perceived expertise, interpersonal trust and partnership (26). Studies that demonstrate poor patient adherence make it clear that patients frequently disagree with physicians' diagnosis and treatment plans; this leads to unfilled prescriptions, partially used medications, lack of follow-up with referrals and return visits and poor outcomes (27). Regional studies in the Caribbean also show that clinic staff-client communication seems to play a major role in patient satisfaction and quality of life (28). In settings involving the communication of bad news, the physician who can communicate in a direct and compassionate manner will not only help the patient to cope but also strengthen the therapeutic relationship. This kind of a relationship is likely to endure and further extend the healing process (29, 30).

Patients' perspectives and preferences at the level of individual consultations have been studied (31) and ways identified in which lack of participation has led to misunderstandings that have had actual or potential adverse consequences for taking medicines. The interaction dynamics during the medical encounter are a powerful influence on patients' ability to recall doctors' recommendations, satisfaction, adherence to treatment regimens, and even patients' biomedical health outcomes such as blood pressure and diabetes control (32).

Improved communication has been shown to empower patients for better recuperation after surgery (33). A training programme geared at improving communications skills of health personnel (physicians, nurses and physiotherapists)

led to a decrease in length of hospital stay (by one day), reduction in incidence of post-surgery tachyarrhythmia (by 15%), faster transfer to less intensive care levels and improved patient ratings for communicative quality of care by doctors and nurses (33).

In patients attending an outpatient oncology clinic, a study of patient satisfaction revealed that physician attentiveness and empathy were associated with lower levels of patient distress, higher patient satisfaction and increased patient self-efficacy (34). Physicians who were rated to have lower levels of attentiveness and empathy by patients also displayed a poorer ability to estimate patient satisfaction.

How Communicate?

Effective communication includes the ability to adapt and to be responsive during the process of talking and listening. Additionally, effective communication is not only dependent on the behaviours of the physician but also on the behaviours and perceptions of patients (35). Communication is both a skill and a way of being and it is both innate and teachable (36). The ultimate purpose of communication is the provision of 'whole person care', and so key tasks would include the exploration of psychosocial factors affecting illness, how the illness as well as proposed treatment will affect quality of life of patients and other patient-specific factors (such as personal preferences and circumstances) that will play a role in determining treatment approaches.

Patient-centred communication (PCC) has been widely endorsed as a central component of high-quality healthcare and it describes three core values: (a) considering patients' needs, wants, perspectives and individual experiences, (b) offering patients opportunities to provide input into and participate in their care and (c) enhancing partnership and understanding in the patient-physician relationship (37).

Communications curricula have been shown to significantly improve students' overall communications competence as well as their skills in relationship building, organization and time management, patient assessment, and negotiation and shared decision making—tasks that are important to positive patient outcomes (38).

Several models of patient-physician communication have been employed by a number of medical schools in the United States of America. The most widely implemented is the SEGUE framework which provides a common vocabulary for teaching, learning, assessing and studying communication in medical encounters (39). The basic SEGUE framework is grouped into five sections: **S**et the Stage, **E**licit Information, **G**ive Information, **U**nderstand the Patient's Perspective, **E**nd the Encounter. The SEGUE framework highlights a set of essential communication tasks (*eg*, resident greeted patient appropriately; explained the rationale for the diagnostic procedures *etc*).

The Faculty of Medical Sciences at The University of the West Indies (UWI) employs the Calgary-Cambridge Guide to the medical interview to teach the communication

process in its undergraduate programme. Since its publication in 1998, this guide has been employed widely at all levels of medical education and across a wide range of specialties as underpinning their communications skills programme. It delineates and briefly defines 71 core, evidence-based communication process skills – the latter being a comprehensive repertoire of skills to be employed as needed – and not a list to be slavishly followed (40). This guide, which takes a patient-centred and collaborative approach (41), divides the interview into five major tasks:

- C Initiating the session (including establishing initial rapport and identifying the reason(s) for the consultation)
- C Gathering information (including exploration of problems, understanding the patient's perspective and providing structure to the consultation)
- C Building the relationship (including developing rapport and involving the patient)
- C Explanation and planning (including providing the correct amount and type of information, aiding accurate recall and understanding, achieving a shared understanding that incorporates the patient's perspective and planning that involves shared decision-making) and
- C Closing the session.

The MB BS programme at The University of the West Indies (UWI) Mona Campus, through its 'Introduction to Medical Practice' module which is run for the first two years of the programme, aims to introduce students to the basic skills of medical history-taking and clinical examination and to inculcate in them, at an early stage, the attitudes and behaviours appropriate for the practice of medicine. It includes teaching on areas of professional conduct, including department, patient confidentiality and the importance of communication skills. This is consolidated in the third year, which is devoted to the learning and practising of basic clinical skills. The newly launched MB BS programme at the Cave Hill Campus in Barbados uses the same curriculum as Mona. The sister programme at the St Augustine Campus in Trinidad and Tobago includes 'Communications Skills' as its two compulsory foundation courses, the first of the Caribbean campuses to do so.

Whereas training in communication is increasing at the undergraduate level, it is given far less importance in the postgraduate years, when a physician is training to specialize in a particular medical discipline (42). At the Mona Campus of UWI *eg*, whereas the postgraduate (DM) programme in Internal Medicine has a station in communication skills in its clinical examination, none of the other postgraduate programmes offer any formal training in communication skills, even though it is implied in the objectives of at least some of these programmes.

Five kinds of educational methods have been used in physician training: instruction, modelling, skill practice, feedback and discussions on communication skills. Gen-

erally, the training programmes provide a balance between cognitive learning and experiential learning. Training effects have also been measured in different ways: the physicians' subjective evaluations about training effects, independent behavioural observations of doctor-patient interactions and measurement of outcome effects of the improved interaction with the patient (42).

Regional studies have also shown that physicians who received additional training in communication skills tended to have more satisfied patients (43). Hence if communication skills' training is employed in Continuing Medical Education workshops/seminars geared to practising clinicians, attendance of which is now mandatory in certain territories of the Caribbean for annual registration, it may reap far-reaching benefits in patient care.

Non-verbal communication on the part of the physician has also been shown to improve patient satisfaction and compliance (44). Non-verbal behaviours include facial expressivity, smiling, eye contact, head nodding, hand gestures, postural positions (open or closed body posture and forward to backward body lean), paralinguistic speech characteristics such as speech rate, loudness, pitch and pauses, and dialogic behaviours such as interruptions. Non-verbal behaviour is widely recognized as conveying affective and emotional information (44, 45).

CONCLUSION

The most important issue in effective patient-physician communication is the realization that it is essential for a number of positive patient outcomes. Being mindful of this fact is the first step to improving communication. Critical self-reflection and the courage to face one's own deficiencies can be difficult for even the most conscientious practitioner. Once this hurdle is passed however, communication skills can be strengthened throughout one's professional life, as each patient encounter provides a new experience.

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