Building patient confidence through effective communication

Introduction

The fundamental role of doctors is to:

- Provide high standards of practice and patient care
- Facilitate good relationships with patients and colleagues
- Observe professional ethical obligations.

In order to achieve these, increasing emphasis and importance must be given to clear and effective communication. Doctors fit to practice in the 21st century need not only be clinically competent but must also be effective communicators, managers, teachers and lifelong learners while remaining aware of the health needs of a multicultural society.

Whatever branch of medicine a doctor works in it is likely that, at some time, he/she has discussed the impact of personal values and beliefs have on his/her behaviour towards patients and colleagues. It is also highly probable that such values have been translated into clinical/human resource policies or patient charters, but how well can fine words be translated into good behaviour; what is said and what is done?

Recent high profile cases have clearly demonstrated the potentially disastrous effects of inadequate communication between medical professionals. These include the death of Victoria Climbié, and the public upheaval following the retention of organs without informed consent at Alder Hey. The enquiries following such cases have attempted to protect public confidence in doctors, while their recommendations are intended to reconcile the struggle between public satisfaction and doctors' difficulties.

In the case of Victoria Climbié inadequate communication between colleagues resulted in a failure to link concerns held by several professionals and organizations. Thus no decisive action was taken and the situation was allowed to drift, eventually culminating in Victoria's death. The Alder Hey scandal illustrated how relatives of children became distressed by the lack of communication about tissue retention following death.

Sixty-three other cases have been investigated by the health ombudsman; many of these provide graphic illustration of the ways in which poor communication contributes to, or causes, problems which may result in substandard patient care and further erosion of patients' and relatives' confidence in the medical profession (Rayner, 2003). In the current climate doctors should be able to admit shortcomings openly, learn from mistakes and through such practice develop and improve public confidence.

The vast majority of people in the UK still have confidence in the quality of medical care provided by doctors in the NHS, but occasional mishaps shake public confidence and first hand, high quality communication with patients and their relatives is essential to restore the balance.

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Why is communication important?

Effective communication is central to good medical practice, but is especially important when obtaining informed consent and breaking bad news.

According to the General Medical Council, good communication between patient and doctors is an essential part of a relationship built on trust (General Medical Council, 2001). Owing to recent changes in the working patterns of junior doctors following the implementation of the European working time directive, doctors have to learn communication skills not only from their own educational supervisors but from every member of the health team. A doctor is no longer a solo practitioner but is part of a multidisciplinary team and efficient communication is essential for proper team working.

Easy access to information about health issues through the internet and media make patients better informed and increasingly likely to get involved in decision making about their own care. At the same time, increasing expectations from patients and changes in the doctor–patient relationship coupled with the increasing fear of litigation mean that all health practitioners require excellent communication skills. Poor communication is one of the most common reasons that patients pursue malpractice suits (Vincent et al, 1994; Gorney, 1999). The Medical Protection Society confirms that failure to obtain consent and communication problems are at the core of a number of cases brought before the courts each year.

What has been done so far?

Good communication is actively supported by the General Medical Council through its publication of *The New Doctor* (2005). It has also been identified as an essential requirement by the new Postgraduate Medical Education and Training Board and further reinforced by the Chief Medical Officer in Modernising Medical Careers.

What more needs to be done?

Although increased training has led to improved communication between doctors and patients in recent years, doctors must actively strive to maintain their skills by continuous self-evaluation. Simultaneously education providers need to ensure that training opportunities are available to help doctors refine their skills (Anonymous, 2003).

There is a need for structured, comprehensive training to specifically target communication skills in addition to informal opportunities to develop these skills in clinical settings. The need to assess communication skills during the foundation years has been identified, however, it is still far from adequate as current assessment only looks at a doctor's ability to talk to patients. Coupled with this, the value of interprofessional communication needs to be reinforced by college tutors, educational supervisors and mentors.

General practice has addressed the assessment of communication skills by the use of videotaped consultations during GP registrar training. The authors recommend that the same model should be applied in a hospital setting. This will also enhance the communication skills of the trainers. It is encouraging to see that most Royal colleges now include assessment of such skills in their postgraduate examinations.

Are experienced doctors good at communicating?

Experienced doctors are not necessarily good at communicating. The communication skills of doctors have always and will always be varied and some doctors have been popular with patients purely because of their communication style rather than diagnostic or therapeutic ability. In reality, most patients will tolerate a clinical complication, even when caused by minor negligence, if the error is explained to them by a doctor in an open manner and apologized for. Doctors learn with experience the benefits of apologizing, i.e. saving a lot of future time and potentially avoiding a formal complaint. This keeps the relationship alive, reduces stress and builds and sustains the good reputation of the NHS.

Young doctors often find this premise difficult to digest and mature colleagues often struggle to find time to communicate. On average, physicians listen to patients for 19 seconds before telling them what to do about a problem and there is general dissatisfaction among patients about the length of time doctors spend explaining and planning management to them (McGuire et al, 1986; Laidlaw et al, 2001).

Communication competence

The term communication competence appears cold, but at some stage it will become imperative in day-to-day clinical practice and will be formally assessed for obtaining and maintaining a licence to practise.

The majority of doctors currently feel that they offer adequate explanation to their patients but the results of a study asking patients to list important characteristics related to doctors' medical and communicative ability were slightly surprising. In the study, the five communication themes most frequently listed by patients were: 'understanding', 'talks to me', 'cares', 'listens' and 'respect' and only 58% of doctors were reported to have this kind of competence (Clowers, 2002). In contrast the four themes most commonly identified by medics were 'knows what he is doing', 'is confidential', 'checks for pain' and 'has experience'.

The ten components of an interpersonal communication competence scale are:

1. Empathy
2. Interaction management
3. Supportiveness
4. Expressiveness
5. Environmental control
6. Self-disclosure
7. Social relaxation
8. Assertiveness
9. Altercentrism
10. Immediacy (Rubin and Martin, 1995).

A young doctor probably has no idea what these terms mean and many experienced doctors may not be aware of their importance.

Many of these emotional components are important for patients but are not taught in medical school. Training on emotional intelligence, which one of the authors is championing, is recommended to improve the ability to understand patients' problems and strengthen team working (Gupta, 2005). As emphasized by one of the authors (Gupta and Lingam, 1999), mentorship is required to promote continuous learning and to ensure that taught communication skills are applied effectively. If efforts are made today, over the next decade it can be expected that the public's opinion of doctors will change for the better.

What do we learn from models of communication?

Communication is an inherent skill for some, but with effort most people can become effective communicators.

There are several models available to give an idea of the components that should

be kept in mind while communicating with patients and this article will run through salient points of Buckman (1992)'s CLASS model before outlining the authors' own suggested framework. In this model each letter of the CLASS acronym is used to represent an important aspect of communication skills.

C Context. Includes our non-communicative relationship with the patient, for example privacy, good eye contact, and adequate time

L Listen. Emphasizing the importance for doctors to ask questions and also to probe to establish the patient's concerns

A Acknowledgement. Recognizing the patient's concerns and emotions, and showing an understanding that these are important regardless of their importance to us

S Strategy. Setting out the treatment plan which must include not only the doctor's views but also those of the patient

S Summary. Establishing common goals and expectations.

Another model is found in the Calgary-Cambridge Referenced Observation Guides. This is similar to the CLASS method but emphasis is placed on building a relationship with the patient in a slightly different way (Kurtz et al, 1996). In this model there must be a good understanding between the patient and doctor from first sight to end note.

The authors have developed the BEST model where non-verbal clues and support with emotional channels have been used.

B Begin with non-verbal clues

E Establish information gathering

S Support with emotional channels

T Terminate with positive note.

It is widely acknowledged that over two-thirds of face-to-face conversation is based on body language and that this is an aspect which often goes wrong, leaving patients unsatisfied. As body language differs enormously from culture to culture non-verbal communication skills are especially critical when dealing with residents of Britain's multicultural society. Although beyond the scope of this article this fact should be borne in mind by doctors.

Face-to face *vs* telephonic and written communication

While face-to-face communication is the best way to convey or gather information, time constraints mean that other modes of communication, i.e. telephonic and written modes are increasingly a part of modern medical practice. Referrals are typical examples and when seeking further opinion the clinical issues need to be explicitly expressed. After seeing any patient, appropriate clear and precise opinion must be legibly written in the notes, which then form the basis of a typed reply to the referrer. In the not too distant future, patients will read and approve the referral letter (they already have access to their hospital notes and the Department of Health guidance advises the sending of a copy of the outpatient consultation letter to the patient in addition to the GP).

E-mail is in fashion nowadays and undoubtedly provides fast and effective communication that is now accepted as documentary evidence, but doctors need to be careful of terminology while writing and be cautious about personal whims and fancies. While this is a common means of communication for many health professionals, others do not use it routinely. Some doctors have opened the door to let patients communicate by e-mail, which may be helpful and time saving (e.g. may save a follow-up clinic visit), but one needs to be cautioned against possible misinterpretations of e-mails and security in terms of them being read by the correct person.

Conclusions

Direct patient communication is a key part of patients' experience of the NHS and should be addressed as a component part of the patient journey alongside clinical and other considerations. However, the quality of written and verbal communication to patients is variable, with poor standards needlessly letting the NHS down (Department of Health, 2001).

Formal training of young doctors in communication skills at both undergraduate and postgraduate level will have many beneficial effects including an improved patient outcome, better health-care delivery, good inter-colleague relationships and a high level of confidence of patients in doctors, marking the way towards creating a patient-centred NHS. **BJHM**

Conflict of interest: none.

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KEY POINTS

- The commonest cause of medical litigation is inefficient communication.
- To develop a good patient–doctor relationship, communication skills need to be improved.
- Structured courses focused on communication skills are vital for patient confidence.