Why good communication is worth the effort

Introduction

Developing good interpersonal and communication skills improves your clinical effectiveness as a doctor and reduces your medicolegal risk, resulting in both better patient satisfaction and improved personal wellbeing.

The experience of the Medical Protection Society is that breakdowns in communication and patients' dissatisfaction with doctors' manner and attitude are very frequent themes giving rise to complaints, claims, and even allegations of sexual assault. While this can happen at any stage in a career, the early years when you are building up your skills, experience and confidence can prove particularly challenging.

Various studies have shown that the quality of medical care is not the only thing that determines whether a patient will sue.

Why do patients sue?

The Harvard Medical Study (Leape et al, 1991) found that 3.7% of admissions to New York city hospitals were associated with adverse events, but only one in four adverse outcomes was the result of negligence. Only 12% of patients who suffered negligence filed a law suit, but two out of three claims were brought by patients with no adverse outcome or an adverse outcome not resulting from negligence.

Research published by Bunting et al (1998) suggests that there are two sets of factors which influence the decision to sue:

- Predisposing factors – rudeness, delays, inattentiveness, miscommunication, apathy, no communication
- Precipitating factors – adverse outcomes, iatrogenic injury, failure to provide adequate care, mistakes, incorrect care, system errors.

It is suggested that precipitating events are unlikely to lead to litigation in the absence of predisposing factors, yet media articles tend to report on precipitating rather than predisposing factors.

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The role of communication

Levinson et al (1997) reported that a breakdown in communication between doctor and patient is a critical factor; and in 1985, Avery reported that lawyers identified doctors' communication and attitudes as the primary reason for patients pursuing malpractice suits in 70% of cases. Beckman and colleagues (1994) surveyed the records of malpractice claims made in the 1980s in the USA; in over 70% of cases, the following communication problems were cited:

- Deserting the patient
- Devaluing the patient's view
- Delivering information poorly
- Failing to understand the patient's perspective.

And it is not just litigation that can arise – complaints, medical council enquiries, and even police investigations are associated with poor communication (*Figure 1*).

There are understandable difficulties for patients in assessing the technical competency of a doctor, and they frequently judge the quality of clinical competence by their experience of their interpersonal interactions with a doctor. A MORI (2005) poll published in July 2005 confirmed that the top characteristic the public wanted to comment on in relation to their doctor's performance was their communication skills, followed by whether they are up to date, how much they involve patients in treatment decisions and whether they show their patients dignity and respect. While patients want doctors to have good clinical and technical skills, they rate interpersonal skills as more important.

Figure 1. Consequences of misinterpretation.

A young woman presented to accident and emergency complaining of a severe sore throat and malaise. She was examined by a junior doctor who, having found cervical lymphadenopathy, proceeded to examine the axillae and the groin. Some hours later, he was shocked and mortified to learn that the patient had made a complaint to the police that she had been touched inappropriately and indecently. If he had explained to the patient what he was going to do, and why, he would have avoided an unpleasant complaint and stressful police interview.

Managing patients' expectations

Patients will be dissatisfied if their expectations have not been met. Those expectations may be reasonable and realistic – for example, that the doctor will have adequate time, will listen, be interested and respectful, and be competent. Other expectations may be unrealistic – that the doctor has unlimited time and availability, will solve all the issues at once and all treatments will be 100% effective and risk free. The gap between what the doctor can deliver and what the patient expects can only be addressed if it is identified, and that means asking and exploring so that any unrealistic views can be respectfully corrected as they arise.

How to communicate effectively

The words we use are less important than the tone of voice or our body language. Carson (1990) reports that 80% of communication is non-verbal, and doctors with good non-verbal communication skills are rated as more caring by their patients.

First, let your patients tell you their story. Beckman et al (1994) found that the mean time taken for a doctor to interrupt a patient's opening statement was 18 seconds. Patients do not present problems in order of clinical importance, and if you let patients speak uninterrupted, they rarely continue beyond a minute. The longer you wait before interrupting, the more likely you are to discover the full spread of concerns the patient wants to discuss, and the less likely it is that new issues will be brought up just as you are concluding a consultation. Eye contact is critical in demonstrating interest and understanding, particularly at the beginning and end of the consultation. So turn away from the computer, and pay attention. Summarizing what you have heard, and checking your understanding, helps the patient feel understood and appreciated.

'Listening with your eyes'

A member recently wrote to the Medical Protection Society with her own experience (Anonymous, 2006). A patient on the intensive care unit had had multiple pathology and a tracheostomy. He remained conscious, but was very dis-

tressed and mouthing words which could not be understood by the medical team. A drawing board was of no avail. A member of the team stayed behind after the ward round, and with the use of careful questions, finger counting and patience, established that he had lost his vision 5 days previously, undetected by the team of specialist doctors and nurses.

Telephone calls

All the non-verbal cues and clues that help in face-to-face communication are clearly not available in phone conversations, so there is a need for greater clarity in verbal skills. When speaking to patients, remember your responsibilities to maintain confidentiality, so try to speak where you will not be inappropriately overheard, and be careful about revealing your identity until you have confirmed that you are speaking to the patient, not a friend or relative. Make sure you document the consultation in the patient's records.

Communication with the team

The focus of this article has been on communicating effectively with patients, but the same principles apply to sharing information within your team, across teams and between primary and secondary care. This is essential for patient safety, and the practice of good medicine (*Figure 2*).

Communicating if things go wrong

Despite the best of intentions there will be occasions when patients or their relatives will be dissatisfied with the care you have provided, or with the outcome they have experienced. This may be a result of human error, systems failure or unmet expectations. Complaints feel personal, hurtful and sometimes unfair. It is wise to discuss the situation with an experienced colleague or your medical protection organization. Above all try to retain your professionalism, making sure that you:

- Acknowledge the complaint
- Find out the facts
- Provide an explanation
- Apologise where appropriate
- Identify what can be done to prevent similar issues arising
- Adopt those lessons into your future practice.

Malcolm Thomas (2005a) has summarized the current literature on communication behaviours which reduce medicolegal risk (*Table 1*). His chapter on 'Communication and Risk: Some Answers' (Thomas, 2005b) is a useful resource for those seeking guidance on further development of communication skills.

Table 1. Communication behaviours to lower medicolegal risk

Being available (returning phone calls, making and keeping appointments), especially if something has gone wrong
Giving the impression that you have sufficient time for the patient (which can be done without taking up much extra time, and is achieved by not giving out 'rushed' signals)
Soliciting and understanding the patient's viewpoint
Demonstrating empathy
Demonstrating 'acceptance'
Explaining the process of the consultation
Giving explanations that are pitched at the patient's level

From Thomas (2005a)

Conclusions

Newly qualified doctors enter the world of patient interaction with their heads stuffed full of clinical information, and it may seem that all that is needed is expertise, knowledge and technical competence. Yet all of these hard-won skills and knowledge, vital as they are, are not sufficient in themselves to make a good doctor. The vital ingredient is good communication and this, like all skills, has to be acquired through hard work, experience and application. You are half-way there, however, if you recognize that time spent talking and listening to patients is not time wasted, and that all patients are deserving of respect. BJHM

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Figure 2. Effective handover.

A middle-aged man presented to accident and emergency with a history of indigestion and belching over the previous 2 hours which had now settled. An electrocardiograph appeared normal and he wanted to go home. Dr Jones considered a diagnosis of dyspepsia but arranged a blood test for troponin as a precaution. He was going off duty and told nursing staff that the patient could be discharged once the results had been seen and checked.

Dr Brown took over, unaware that these results were awaited. She was told by the nurses that the patient was to be discharged, and she did not see any reason to intervene.

The patient was readmitted several hours later with a massive myocardial infarction; he arrested and could not be resuscitated. The original blood test confirmed early elevation of enzyme levels which, if acted on, might have prevented the death.

KEY POINTS

- Litigation arises from a combination of predisposing and precipitating factors.
- Patients' assessment of clinical competence is based on interpersonal skills.
- Doctors can reduce predisposing risk factors by paying attention to their communication skills.