

Ten steps to better communication

Good communication skills are the foundations on which a good doctor–patient relationship is established. They have a significant influence on patient satisfaction and are likely to lead to a more satisfying career in medicine. This article is aimed at medical students and trainees in the early stage of their career, and it focuses on the key ingredients of good communication (Table 1).

Introduction

A good interviewing technique is essential in all specialities. It is likely to lead to a more fulfilling career by improving the quality of the relationship between the patient and doctor. Communication skills can be enhanced by training, leading to increased patient satisfaction and well-being (Maguire, 1986). The depersonalization of medicine has downgraded the importance of history taking in favour of structured data collection and interpretation of results.

The doctor–patient relationship is characterized by mutual respect and understanding and is the cornerstone of good medical care. The clinician's active listening and the ability to ask questions with psychological content is associated with the ability to identify the patient's emotional problems (Giron et al, 1998). Good

communication skills also improve outcome (Simpson et al, 1991).

Most complaints against doctors are not linked to competence but to poor communication (Richards, 1990). Doctors do not always allow their patients to tell them about their problems. In one study patients were interrupted on average 18 seconds after they had started speaking; as a consequence they failed to disclose significant concerns (Beckham and Frankel, 1984).

Functions of communication

There are three essential functions of communication. They are gathering information, building rapport, and educating and motivating patients (Bertakis, 1991; Lipkin et al, 1995). The doctor is the expert in his/her chosen speciality and the patient is the expert on his/her illness and body. It is therefore important that through the medium of communication both are able to inform each other about their area of expertise. Communication should serve the patient's need to tell the story of his or her illness and the doctor's need to hear it.

Setting the scene

A good interview requires careful planning. Time spent setting the scene is likely to pay significant dividends later on. You and your patients are going to spend a considerable period of time sitting in this room. Try and find some comfortable chairs for both of you. Have chairs at an equal height so that neither person is sitting higher than the other, allowing the interaction to be more equal. Keep a fair distance so you are neither too far from the patient nor are you invading his/her personal space.

The room where you see your patient should be well lit and quiet. It should offer the privacy that the appointment deserves. It is good practice to keep your phone on silent since patients sometimes wait weeks if not months to see you for a 15-minute consultation.

If you are seeing patients in your own office try and avoid any personal effects such as photographs, which might give the patient information about your personal life and could have an impact on the transference (see below).

Get the patient's name right. Have a system that you follow for your history taking. Clarify your own agenda for the meeting. The beginning and the end are important in improving patient satisfaction and outcome respectively. The beginning includes the initial introduction which puts the patient at ease while the end of the interview involves checking understanding and clarifying information (Maguire et al, 1986).

Consider the time of the day when you would like to see the patient and also the length of time you want to see them for. Consider the length of your appointments; short visits can be linked to fewer problems being identified and fewer preventative actions being taken (Howie et al, 1997), although at other times shorter appointments may be appropriate.

Dress smartly. First impressions always count. How you dress and present yourself will influence the patient's views on your professionalism and competence.

First impressions

Start each interview by introducing yourself and adopt a warm friendly manner. See your patient on time, be polite, open the door for your patient and invite him/her to sit down. Tell the patient your name, what you do and what your designation is. You might want to think about giving a brief idea of your professional experience and also the service that you work in. Define your role – it is useful for patients to know what you can and can't do.

This can then lead on to the patient introducing him-/herself. Ask how he/she would like to be addressed. It is easy to forget these introductions especially when you are rushing between patients. Introductions give both of you a chance to pause and orientate yourselves to the meeting.

It is helpful for the patient to know what the purpose of the meeting is, especially if the patient has been referred to you by another doctor. Sometimes patients feel confused when they have seen different doctors in a short space of time.

Let your patient know how long the interview will last for, especially if it is a new assessment. It is also useful to ascertain the patient's expectations at the start;

Table 1. Ten steps to better communication

1. Setting the scene
2. First impressions
3. Verbal and non-verbal communication
4. Open and closed questions
5. Clarify and check understanding
6. Transference and countertransference
7. Therapeutic alliance
8. Listening and reassurance
9. Motivational interviewing
10. Authenticity

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his/her agenda might be very different from yours (Quill, 1983).

Read notes in advance; patients are pleasantly surprised when you know their history well, and it can look bad if you have to rummage through the notes in front of the patient. Try and keep note taking to a minimum during the interview. Write down key points and dates but otherwise it is better to give the patient your full attention rather than spend time writing.

Verbal and non-verbal communication

Non-verbal communication is communication that does not have linguistic content (Knapp and Hall, 2005). The key parts of non-verbal behaviour are facial expressions, smiling, eye contact, head nodding, hand gestures, posture and paralinguistic speech characteristics such as pitch, tone and volume. Non-verbal communication is like the submerged part of the iceberg of communication. It can have far a greater impact than verbal communication. Emotion, for example, is far better conveyed non-verbally.

Give your patient your full attention. Greater eye contact is associated with more effective reading of emotional cues and better recognition of psychosocial distress (Bensing et al, 1995). Make reflective comments to show you are listening. It is worth considering mirroring techniques such as matching the patient's volume and tone of speech, especially when the patient is anxious or low. Be polite and courteous, apologize if interruptions occur. Start by having unconditional positive regard for your patient. What you and the patient say to each other is likely to be the main focus of the interview, but it is the non-verbal communication that is likely to tell you more about each other and have the greater influence on the meeting.

It is crucial that both the patient and you understand each other. It is therefore important that you speak slowly and clearly. Use simple language, avoid jargon, and don't try to blind your patient with science. Match your language with the patient's expectations. In today's globalized world both doctors and patients are likely to have encounters where both parties are from different parts of the world. In this situation speaking slowly and clearly increases the likelihood of

good communication. Leave pauses allowing for the patient to interrupt if he/she wants to. Avoid interrupting the patient mid sentence.

Open and closed questions

Open questions are used in cases of hypothesis uncertainty. They allow patients to select the direction in which they would like to take their answers. Closed questions on the other hand have a one-word answer such as 'yes' or 'no'. It is good practice to start with open questions and then lead on to closed questions. This gives the patient the opportunity to focus on issues that are more important to him/her. It also allows the meeting to be less directive and you will learn more listening to the patient's story in his/her own words than by turning it into a question and answer session. One study estimated that the primary complaint was only brought up by 20% of patients at the end of the interview (White et al, 1994), probably because they were not allowed to speak freely at the start.

Patients won't necessarily tell you their story in the order in which you want to hear it. Let the patient tell his/her story – you can then fill in the blanks later. Avoid a scripted exchange. Ask about the illness in the context of the patient's life. Avoid leading questions; these can result in distorted information.

Clarify information and check understanding

At each stage clarify information so you understand what the patient has said and vice versa. A patient is more likely to go away feeling satisfied with the interview if he/she feels understood and you are more likely to get a better idea of the patient's problems if you have clarified any doubts that you might have had.

Sometimes patients like to talk about what they feel is important while there might be other issues that need highlighting. You could meet a patient who is circumstantial and slow in the description of his/her problems or is hypo-manic and is unable to keep things on track. On these occasions it becomes important to control the interview. This can be done by politely interrupting the patient and reminding him/her of the limited time that you have together. Questions can then be more focussed allowing for a fruitful interview.

If it continues to be difficult it is helpful to break up the assessment into more than one interview.

Transference and countertransference

Transference is the phenomenon whereby the patient unconsciously transfers feelings and attitudes from a person or situation in the past onto the clinician. Countertransference on the other hand is the response that is elicited in the clinician by the patient's communications.

We often encounter difficult patients who produce negative countertransference in us. It is important to be aware of this and to learn from it. Always adopt a neutral approach to difficult patients. Explore your own attitude, beliefs and expectations. Patients with personality disorders are most likely to produce a negative countertransference reaction. With their defences of projection and splitting we tend to feel less warmth and empathy towards them. This can then affect our judgment of their illness and also impact on the management plan.

Therapeutic alliance

It is the relationship between the patient and the clinician that allows mutual collaboration between the two with the aim of helping understand the patient's problem and treating it. The foundation of the therapeutic alliance is based on the trust in the competence, discretion and empathy of the clinician.

The therapeutic alliance is the most important predictor of outcome in therapy (Martin et al, 2000). Irrespective of the modality of the therapy or the treatment the positive alliance between the doctor and patient is likely to improve the outcome. Patient satisfaction is linked to the interpersonal relationship and the relationship can be the treatment in itself.

Rapport and empathy are invaluable in developing a therapeutic alliance. Rapport is the result of warmth and understanding between the patient and the clinician. The clinician who is able to better connect with the patient is more likely to develop a good rapport with the patient. Humour is an invaluable tool in building rapport. Interviews do not have to be sombre occasions even though you are dealing with serious issues.

It is often the conversations we have about things other than illness that lead to a better rapport with our patients. Time spent in understanding human nature and the world at large is more likely to help us understand our patients. Personal development outside the work place will have a significant positive impact on your ability to communicate with others.

For patients who are anxious and are experiencing distressing symptoms empathy from the clinician can have significant therapeutic value. The five elements of empathy are reflection, legitimation, respect, support and partnership (Cohen-Cole, 1991). The expression of empathy significantly enhances the quality of the interview and contrary to expectations does not prolong the duration of the interview (Bertakis, 1991).

Listening and reassurance

It is very easy to underestimate the relief that patients and indeed all human beings feel from being listened to. Sometimes there is very little we can actively do to help a patient. For example in the case of bereavement a biological approach is not likely to make a significant difference in helping the patient deal with a loss. It is at times like these where listening alone can be a big help, especially with patients who do not have any other confiding relationships in their lives.

A lot of patients seek reassurance from their doctors. There will be times when reassurance is appropriate, especially in the management of an acutely ill patient. On the other hand there will be situations when a patient will want you to be able to listen and 'hold' on to his/her fears and anxieties for him/her – your reassurance during this time might be seen as a rejection of their distress. Premature advice and reassurance is therefore not always helpful.

Motivational interviewing

The clinician can often act as a motivator as patients see him/her as positive role models. Every meeting with our patients can be used as an opportunity to effect change. The interview can go beyond communication and can be seen as a means to effecting change, this can be done through motivational interviewing. The key principles of motivational interviewing are express empathy, develop discrepancy,

avoid arguments, 'roll with' resistance and support self-efficacy (Miller and Rollnick, 2002). The goal of motivational interviewing is to prepare people for change rather than push people into change. It is a skill that can be incorporated into clinical practice. As clinicians facilitation and negotiation skills can be invaluable in improving outcome.

Patients find it very helpful when they leave the appointment with a written plan. It acts as an aide memoir between appointments. For the plan to be effective the plan needs to be individualized and make use of the strengths of the patient. A written plan made in collaboration with the patient helps inform him/her about what happens next and also makes him/her an active partner in the treatment.

Authenticity

The above skills need to be amalgamated with your own personality. Be authentic – if you are just going through a list of questions, the patient will sense it. When you are more relaxed and comfortable the patient responds accordingly and this allows the whole experience of the interview to be more satisfying.

Conclusions

The use of interview skills is an invaluable part of our clinical lives. With practice we can all improve our communication skills (Roter, 1995).

Good communication skills can be learned and taught. Doctors and patients shape their relationship, each group influencing the other, and, by the very nature of their relationship, define the process and outcomes of care (Roter and Hall, 2006). There is room for greater emphasis on training in communication skills both at the undergraduate and postgraduate level in all specialities. **BJHM**

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KEY POINTS

- Good communication skills increase patient satisfaction and improve outcome.
- Non-verbal communication can have a far greater impact on the doctor–patient interaction than verbal communication.
- Be aware of the transference and countertransference during the interview.
- Every meeting with patients can be an opportunity to effect change through motivational interviewing.
- Authentic interactions are critical to developing a therapeutic relationship.