Does Teaching Doctor-Patient Communication Skills Make a Difference?

What is the Evidence?

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Plan

Why teach communication skills?

- is it important to study the medical interview?
- are there problems in communication between doctors and patients?
- is there evidence that communication skills can overcome these problems and make a difference to patients, doctors and outcomes of care?

Can you teach and learn communication skills?

- is there evidence that communication skills can be taught and learned?
- is there evidence that learning is retained?
- do we know which methods of learning work?

Is the prize on offer to doctors and patients worth the effort?

- will expending the effort on communication skills teaching produce worthwhile rewards for both doctors and patients?

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Why teach communication skills?

- is it important to study the medical interview?

Effective communication

is essential to the practice of

high quality medicine

The average doctor undertakes

200,000 consultations in a

professional lifetime!

CLINICAL COMPETENCE

The ability to integrate:

- knowledge
- communication
- physical examination
- problem-solving

THE VERY ESSENCE OF CLINICAL PRACTICE

Communication is a core clinical skill

The goals of medical communication

- Ensuring more effective interviews:
  - ↑ accuracy
  - ↑ efficiency
  - ↑ supportiveness
- Enhancing patient and doctor satisfaction
- Improving health outcomes for patients
- Promoting collaboration and partnership

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Why teach communication skills?

- is it important to study the medical interview?
- **are there problems in communication between doctors and patients?**

Are there problems in communication between doctors and patients?

- **reasons for the patient's attendance**
- **gathering information**
- **explanation and planning**
- **adherence to plans**
- **medico-legal**
- **lack of empathy and understanding**

Kurtz, Silverman and Draper (1998; 2nd Ed in press)
Teaching and Learning Communication Skills in Medicine
Radcliffe Medical Press

Silverman, Kurtz and Draper (1998; 2nd Ed in press)
Skills for Communicating with Patients
Radcliffe Medical Press

Discovering the reasons for the patient's attendance

- **54% of patients' complaints and 45% of their concerns are not elicited** (Stewart et al 1979)
- **in 50% of visits, the patient and the doctor do not agree on the nature of the main presenting problem** (Starfield et al 1981)
- **only a minority of health professionals identify more than 60% of their patients' main concerns** (Maguire et al 1996)
- **consultations with problem outcomes are frequently characterised by unvoiced patient agenda items** (Barry et al 2000)
- **doctors frequently interrupt patients so soon after they begin their opening statement that patients fail to disclose significant concerns** (Beckman and Frankel 1984, Marvel et al 1999)
- **doctors often interrupt patients after the initial concern, apparently assuming that the first complaint is the chief one, yet the order in which patients present their problems is not related to their clinical importance** (Beckman and Frankel 1984)

Gathering information

- doctors often pursue a "doctor-centred", closed approach to information gathering that discourages patients from telling their story or voicing their concerns (Byrne and Long 1976)
- both a "high control style" and premature focus on medical problems can lead to an over-narrow approach to hypothesis generation and to inaccurate consultations (Platt and McMath 1979)
- oncologists preferentially listen for and respond to certain disease cues over others – while pain amenable to specialist cancer treatment is recognised, other pains are not acknowledged or are dismissed (Rogers and Todd 2000)
- doctors rarely ask their patients to volunteer their ideas and in fact, doctors often evade their patients' ideas and inhibit their expression. Yet if discordance between doctors' and patients' ideas and beliefs about the illness remains unrecognised, poor understanding, adherence, satisfaction and outcome are likely to ensue (Tuckett et al 1985)
- doctors only respond positively to patient cues in 38% of cases in surgery and 21% in primary care (Levinson 2000)

Explanation and planning

- in general, physicians give sparse information to their patients, with most patients wanting their doctors to provide more information than they do (Waitzkin 1984, Pinder 1990, Beisecker and Beisecker 1990, Jenkins et al 2001, Richard and Lussier 2003)
- doctors overestimate the time they devote to explanation and planning in the consultation by up to 900% (Waitzkin 1984, Makoul et al 1995)
- patients and doctors disagree over the relative importance of imparting different types of medical information; patients place the highest value on information about prognosis, diagnosis and causation of their condition while doctors overestimate their patient's desire for information concerning treatment and drug therapy (Kindelan and Kent 1987)
- doctors consistently use jargon that patients do not understand (Svarstad 1974, Hadlow and Pitts 1991)
- there are significant problems with patients' recall and understand of the information that doctors impart (Tuckett et al 1985, Dunn et al (1993)
- only the minority of patients achieve their preferred level of control in decision making in cancer treatment (Degner et al 1997)

Patient adherence

- patients do not comply or adhere to the plans that doctors make: on average 50% do not take their medicine at all or take it incorrectly (Meichenbaum and Turk 1987, Butler et al 1996)
- non-compliance is enormously expensive. The cost of wasted funds spent on prescription medications used inappropriately or not used in Canada amounts to 5 billion a year, based on an annual expenditure of 10.3 billion and data indicating that 50% of prescription medications are not used as prescribed. Estimates of the further costs of non-adherence (including extra visits to physicians, laboratory tests, additional medications, hospital and nursing home admissions, lost productivity and premature death) were CAN$ 7-9 billion in Canada (Coambs et al 1995) and US$billion plus in the US (Berg et al 1993)

Medico-legal issues

- breakdown in communication between patients and physicians is a critical factor leading to malpractice litigation (Levinson 1994). Lawyers identified physicians' communication and attitudes as the primary reason for patients pursuing a malpractice suit in 70% of cases (Avery 1986).
- Beckman et al (1994) showed that the following four communication problems were present in over 70% of malpractice depositions: deserting the patient, devaluing patients' views, delivering information poorly and failing to understand patients' perspectives.
- Patients of obstetricians with a high frequency of malpractice claims are more likely to complain of feeling rushed and ignored and receiving inadequate explanation, even by their patients who do not sue. (Hickson et al 1994)
- in several states of the USA, malpractice insurance companies award premium discounts of 3 to 10% annually to their insured physicians who attend a communication skills workshop (Carroll 1996)

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Lack of empathy and understanding

- numerous reports of patient dissatisfaction with the doctor-patient relationship appear in the media. Many articles comment on doctors' lack of understanding of the patient as a person with individual concerns and wishes
- there are significant problems in medical education in the development of relationship building skills: it is not correct to assume that doctors either have the ability to communicate empathically with their patients or that they will acquire this ability during their medical training (Sanson-Fisher and Poole 1978, Suchman and Williamson 2003)

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We now have research evidence to validate the use of specific communication skills:

- process of the interview
- satisfaction
- recall and understanding
- adherence
- outcome: decreased patient concern
  symptom resolution
  physiological outcome

Process of the interview

- the longer the doctor waits before interrupting at the beginning of the interview, the more likely she is to discover the full spread of issues that the patient wants to discuss and the less likely will it be that new complaints arise at the end of the interview (Beckman and Frankel 1984, Joos et al 1996, Marvel et al 1999, Langewitz et al 2002)
- the use of open rather than closed questions and the use of attentive listening leads to greater disclosure of patients' significant concerns (Cox 1989, Maguire et al 1996, Wissow et al 1994)
- asking "what worries you about this problem" is not as effective a question as "what concerns you about this problem" in discovering unrecognised concerns (Bass and Cohen 1982)
- the more questions patients are allowed to ask of the doctor, the more information they obtain (Tuckett et al 1985)
- picking up and responding to patient cues *shortens* rather than lengthens visits (Levinson et al 2000)

Patient satisfaction

- greater "patient centredness" in the interview leads to greater patient satisfaction (Stewart 1984, Arborelius and Bromberg 1992, Kinnersley et al 1999, Little et al 2001)
- discovering and acknowledging patients' expectations improves patient satisfaction (Korsch et al 1968, Eisenthal and Lazare 1976, Eisenthal et al 1990, Bell et al 2001)
- physician non-verbal communication (eye-contact, posture, nods, distance, communication of emotion though face and voice) is positively related to patient satisfaction (DiMatteo et al 1986, Weinberger et al 1981, Larsen and Smith 1981, Griffith et al 2003)
- patient satisfaction is directly related to the amount of information that patients perceive they have been given by their doctors (Hall et al 1988)
- information giving, expression of affect, relationship building, empathy and higher patient centeredness lead to increased patient satisfaction. (Williams S, Weinman et al 1998)
- in cancer patients, satisfaction with the consultation and the amount of information and emotional support received are all significantly greater in those who reported a shared role in decision making. (Gattellari et al 2001)

Patient recall and understanding

- asking patients to repeat in their own words what they understand of the information they have just been given increases their retention of that information by 30% (Bertakis 1977)
- there is decreased understanding of information given if the patient's and doctor's explanatory frameworks are at odds and if this is not discovered and addressed during the interview (Tuckett et al 1985)
- patient recall is increased by categorisation, signposting, summarising, repetition, clarity and use of diagrams (Ley 1988)
- the provision of audio or video tapes of the actual interview and writing to patients after their consultation increase patient satisfaction, recall, understanding and patient activity (Tattersall et al 1997, McConnell et al 1999, Sowden et al 2001, Scott et al 2001)

Adherence

- patients who are viewed as partners, informed of treatment rationales and helped in understanding their disease are more adherent to plans made (Schulman 1979)
- doctors can increase adherence to treatment regimens by explicitly asking patients about knowledge, beliefs, concerns and attitudes to their own illness (Inui et al 1976, Malman et al 1988)
- discovering patients' expectations leads to greater patient adherence to plans made whether or not those expectations are met by the doctor (Eisenthal and Lazare 1976, Eisenthal et al 1990)
- consultations using a structured exploration of patients' beliefs about their illness and medication and specifically addressing understanding, acceptance, level of personal control and motivation leads to improved clinical control or medication use even three months after the intervention ceased (Dowell et al 2002)

Outcome

Symptom resolution

- resolution of symptoms of chronic headache is more related to the patient's feeling that they were able to discuss their headache and problems fully at the initial visit with their doctor than to diagnosis, investigation, prescription or referral **(The Headache Study Group 1986)**
- training doctors in problem-defining and emotion-handling skills not only leads to improvements in the detection of psychosocial problems but also to a reduction in patient's emotional distress up to six months later **(Roter et al 1995)**
- in the management of sore throat, satisfaction with the consultation and how well the doctor deals with patient concerns predicts the duration of illness **(Little et al 1997)**
- patient-centred communication is associated with better recovery from discomfort and concern, better emotional health two months later and fewer diagnostic tests and referrals **(Stewart et al 2000)**

Outcome

Physiological outcome

- giving the patient the opportunity to discuss their health concerns rather than simply answer closed questions leads to better control of hypertension **(Orth et al 1987)**
- decreased need for analgesia after myocardial infarction is related to information giving and discussion with the patient **(Mumford et al 1982)**
- providing an atmosphere in which the patient can be involved in choices if they are available leads to less anxiety and depression after breast cancer surgery **(Fallowfield et al 1990)**
- patients who are coached in asking questions of and negotiating with their doctor not only obtain more information but actually achieve better BP control in hypertension and improved blood sugar control in diabetes **(Kaplan et al 1989, Rost et al 1991)**

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Can you teach and learn communication skills?

- **is there evidence that communication skills can be taught and learned?**

Can communication skills be learned?

- **communication is a clinical skill**
- **it is a series of learnt skills**
- **experience is a poor teacher**

Can communication skills be learned?

- **there is conclusive evidence that communication skills can be taught**

Aspergren K (1999)

Teaching and Learning Communication Skills in Medicine: a review with quality grading of articles

Medical Teacher 21 (6)

- Overwhelming evidence for positive effect of communication training
- Medical students, residents, junior doctors, senior doctors
- Specialists and general practice equally

- **Rutter and Maguire (1976)** showed in a controlled trial that medical students who underwent a training programme in history-taking skills reported almost three times as much relevant and accurate information after a test interview as those who received only the traditional apprenticeship method of learning history-taking skills. **Confirmed by Irwin and Bamber (1984) and Evans et al (1989).**

- **Evans et al (1991)** showed that medical students who learned key interviewing skills were diagnostically more efficient and effective in interviewing medical and surgical patients (i.e. that the improved behaviours and skills developed in training led to an increase in clinical proficiency) and yet took no more time with interviews than untrained students

- **Langewitz et al. (1998)** demonstrated that specific patient-centred communication skills can be taught to residents in internal medicine over a 6-month period.
- **Smith et al. (1998)** showed that a one month intensive training course in interviewing and related psycho-social topics for primary care residents improved their knowledge about, attitudes toward and skills in interviewing, with both real and simulated patients.
- **Humphris and Kaney (2001)** demonstrated an improvement in communication skills in medical students over 17 months of their undergraduate teaching following a comprehensive and on-going communication skills course.
- **Fallowfield et al. (2002)** showed that senior clinicians working in cancer medicine have many difficulties when communicating with patients, with patients' relatives and with professional colleagues. In a randomised controlled trial of 160 oncologists from 34 UK cancer centres, an intensive 3-day training course produced significant subjective and objective changes in key communication skills three months later
- **Yedidia et al. (2003)** evaluated the effects of a communications curriculum instituted at 3 US medical schools. The curriculum significantly improved third-year students' overall communications competence as well as their skills in relationship building, organization and time management, patient assessment, negotiation and shared decision making-tasks.

Can communication skills be learned?

- there is conclusive evidence that communication skills can be taught
- **and that communication skills teaching is retained**

- **Stillman et al (1977)** demonstrated that trained students maintained their post-training superiority over their non-trained peers at follow up a year later
- **Maguire et al (1986)** followed up their original students five years after their training. They found that both groups had improved but those given communication skills training had maintained their superiority in key skills such as using open questions, clarification, picking up verbal cues and coverage of psychosocial issues. These effects were found in interviews with patients with both psychiatric and physical illnesses
- **Bowman FM et al (1992)** showed that the improvement in interviewing skills of established general practitioners following an interview training course was maintained over a two year follow-up period
- **Oh et al (2001)** showed that trained medicine residents use of patient-centred interviewing skills significantly improved after an intensive course and these improvements were maintained for 2 years.

Can communication skills be learned?

- there is conclusive evidence that communication skills can be taught
- and that communication skills teaching is retained
- **do we know which methods of learning work?**

Which methods of learning work

- **Maguire et al 1978** randomised medical students into four training conditions and discovered the following key steps:
  - the provision of detailed written guidelines of the areas to cover and the skills to use
  - the opportunity to practice interviewing under controlled conditions
  - observation by both self and facilitator
  - the provision of feedback by an experienced facilitator with the aid of audio or video tape

- **Evans et al (1989)** compared
  - a series of 5 one hour lectures covering the background to communication training and the verbal, non-verbal and listening skills that were helpful in the medical interview. Students were given comprehensive hand-outs, including relevant theory and research.
  - 3 two hour workshops, after the lectures, using experiential methods such as role play, discussion, videotaping with real and simulated patients and feedback

You won't learn communication skills from listening to this lecture!

How do we change our behaviour in the interview?

Knowledge is important but only allows you to know about communication

Experiential teaching is required to know how to communicate

How to teach communication skills – lessons from the evidence

- systematic delineation and definition of the skills
- observation of learners
- video or audio recording and review
- well-intentioned feedback
- rehearsal
- active small group or 1:1 learning

What experiential material is available to you?

- videos of real consultations
- real patients
- simulated patients
- role-play

A curriculum rather than a course

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Can you teach and learn communication skills?

- is there evidence that communication skills can be taught and learned?
- is there evidence that learning is retained?
- what methods of learning have been shown to work?

Is the prize on offer to doctors and patients worth the effort?

- **will expending the effort on communication skills teaching produce worthwhile rewards for both doctors and patients?**

The prize on offer from effective communication in the medical interview

- Not just being supportive
- Improves clinical performance
- Improves outcomes for patients
- Improves health outcomes for doctors

The goals of medical communication

- Ensuring more effective interviews:
  - ↑ accuracy
  - ↑ efficiency
  - ↑ supportiveness
- Enhancing patient and doctor satisfaction
- Improving health outcomes for patients
- Promoting collaboration and partnership

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