

Invited Article

Effective Communication Skills for Medical Practice

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"The basic building block for good communication is the feeling that every human being is unique and of value." Anonymous

Abstract

Medical communication has received much attention over the past few decades. There is an increasing demand on doctors to be more effective communicators, especially when dealing with patients and their caregivers. Doctors can be trained to become better communicators and such training has other benefits for doctors. While modern undergraduate curricula allocate much time for effective communication, its emphasis during postgraduate training appears to be insufficient. In this paper, basic principles of effective communication in medical practice will be discussed and some special communication situations highlighted. Teaching-learning methods of communication skills will be discussed, with attention to some of the methods used in Sri Lanka and areas that need improvement. The use of standardized patients in communication skills training will be elaborated. More appropriate assessment methods will be discussed in the light of what is advocated by experts in the field.

Background

"The history of human communication is a story of change, of slow evolutions and abrupt revolutions that altered how we acquired, stored and shared information" says Terrence Moran, an expert on Media Ecology¹. Prehistoric art in the form of carvings, sculptures and other arts is proof of humans communicating with each other from ancient times¹. Long before language developed they would have communicated using non-verbal communication. As humans developed the skill of using language, communicating with others would have vastly improved. With technological advances communication has taken a sudden leap forward, opening new vistas like media (and more recently social media) for exchange of information and ideas.

Doctor-patient communication is not limited to the extraction of the "history" from the patient. Doctors are expected to take the patient as a whole and attend to their needs, fears and concerns during the consultation, adopting a patient-centred attitude. The role of the physician communicator is redefined; the ability of a doctor to provide comfort through their presence and their words is considered to be a fundamental component of good medical care².

Patient satisfaction with doctors is far from optimal, with evidence to say that this is mainly due to ineffective communication³, such as failure to listen and to give information, and lack of concern and respect. Dissatisfaction was not so strong with regard to the technical aspects of care⁴. This has focused increased attention on communication skills (CS) for medical practice.

Reasons for litigation in medical negligence have also centred around aspects like insensitive handling and poor communication, after the initial damage⁵. This has prompted certain medical defense companies in the USA to award discounts for insurance premiums to doctors who attend workshops in communication⁶.

Good medical communicators are more able to detect and respond to emotional distress and have satisfied, less anxious patients who follow the advice given. Additionally, doctors whose communication was effective suffered from less doctor burnout⁷. CS training programmes lead to improved patient outcomes as well as increased personal well-being for doctors⁸.

The endorsement of good CS for doctors by licensing agencies is also quite strong. For example, the General Medical Council⁹ and the Accreditation Council for Graduate Medical Education-International (ACGME-I) both expect doctors to master effective CS. These recommendations have been adopted worldwide for undergraduate and postgraduate training programmes.

The good news is that communication skills (CS) can be acquired¹⁰ and with correct teaching and training can also be retained¹¹. But, it is not enough to train only those who identify themselves as lacking in communication skills, as, interestingly, those who are most confident regarding their CS are often the least competent in communicating with patients¹². Trainers could detect those who are poor communicators using validated assessment instruments and provide them with a training.

Taking this into consideration, current undergraduate curricula of most universities in Sri Lanka and some postgraduate (PG) curricula, both in Sri Lanka¹³ as well as overseas^{14,15}, have dedicated student contact hours for CS teaching. However, considering PG medical education, the time spent on CS teaching appears to be scanty¹⁶ in spite of the fact that, unless practiced regularly during postgraduate training, CS can decline over the years¹¹.

This paper will focus on the basic principles of doctor-patient communication, consider some common difficult communication situations and provide an introduction to teaching learning methods and assessments.

Basics of Medical Communication

There are six core elements in a medical communication (CS)¹⁷. These include initiating the session, gathering information, explanation and planning, and closing the session⁶. Running throughout the communication, are two other core elements; building the relationship and structuring the consultation.

Before initiating the session, the doctor must ensure that the patient is comfortable and reassured, secure and assured of privacy where relevant, in an environment conducive to the interview. In most out-patient departments and clinics, the doctor is seated diagonally across the patient, not too distant, which is more appropriate than facing each other across a desk. Being close to the patient conveys the interest of the doctor in the patient. However, cultural norms and values should be borne in mind, especially in South Asian countries like Sri Lanka where female patients may think it strange if a male doctor draws his chair closer to them.

As the patient comes in, a seat could be offered verbally or by gesture, the patient greeted by name (if possible) and a first easy question asked¹² showing the doctor's interest in him¹⁰. This may appear as dramatizing the medical interview, but even a small gesture to show interest will result in winning the patient's confidence.

The main part of the interview will be focused on gathering information and is discussed under 5 headings. Asking questions, listening, facilitation, signposting, and summarizing.

Questioning is a skill which needs training as, apparently, doctors use long, complicated and confusing questions¹². Open questions are the most suitable in the initial stages. For example “tell me about your problem?” is a good start. However, open questions can lead to irrelevant, long narratives from a talkative patient which the doctor has to handle with tact by signposting. For example by saying, “maybe you could describe the headache” instead of a blunt “please cut off irrelevant details”.

Once the main story is over, the doctor could go on to probing questions to explore the information in greater detail. These questions could be to clarify or justify (for e.g. “What makes you think that?”) or to check accuracy¹². Complex questions and leading questions should be avoided as the answers may not be accurate. Closed questions could be used when all open questions are exhausted and in the withdrawn patient¹³.

Listening is an energy consuming activity in which cognitive, affective and behavioural processes are intertwined¹⁸. Active listening includes both verbal and non-verbal communication.

Active-empathic listening (AEL)¹⁸ is a type of listening which is especially important in close relationships and could be applied to supportive professions like medicine. It is a three-stage activity: sensing, processing, and responding¹⁸. During the sensing stage, the doctor needs to indicate that he is taking in all information by paying close attention, not only to what is said but also to how it is said. In the processing stage the doctor uses the conversation information and constructs a narrative. Responding includes asking questions for clarification and using verbal and nonverbal means to indicate attention. Doctors should listen to the patient without interrupting for at least the first minute or so, whereas many are unable to remain silent and disturb the patient as early as within 18 seconds of commencing the narration³.

Facilitation is a component of active empathic listening where the doctor helps the patient to talk as fully as possible about the disease or incident. It involves putting into action all aspects of effective verbal and non-verbal communication. A reassuring posture, facing the patient, nodding the head in a manner of encouraging the patient and verbal cues like “hmm”, “yes I understand”, “please go on” facilitate active listening.

Before ending the interview, it would be ideal if the main points are summarized so that the patient is reassured that the doctor has understood the problem and the concerns of the patient.

Family and caregivers should be included in the consultation, when appropriate, as they play a crucial role in patient management by facilitating gathering of information. Caregivers may notice some aspects patients do not realize themselves¹².

The explanation and planning stage is one that patient and relatives alike look forward to eagerly so that they can understand what is wrong with the patient and get involved in the patient’s care. Once the physical examination is concluded, doctors need to explain to them regarding the condition and involve them in the planning of subsequent steps like further investigations.

Closing the session is an important aspect that we as doctors may neglect at times. Telling the patient when he has to attend the next clinic would be a hint at closure. Body language can be a means of communicating that the consultation is over.

It should be noted that the doctor-patient relationship is built-up in a spiral manner and the patient should experience this gradual development of bonding. Once the doctor wins the patient's confidence, appropriate words as well as non-verbal communications help in this process. Throughout the interview structure should be provided, in that some organization should be apparent and the flow of the interview should be smooth.

Difficult Communication Situations

Breaking bad news needs much empathy and makes many doctors uncomfortable. It includes giving information, checking patient's understanding, identifying patient's concerns, ascertaining if the patient can cope and offering realistic hope¹². The S-P-I-K-E-S model¹⁹ is advocated for "breaking bad news" and is used in undergraduate training in some Medical Faculties in Sri Lanka²⁰.

Culturally appropriate communication skills is crucial in countries like Sri Lanka where multicultural populations live. For example, some cultures insist on the husband being present during the interview of the wife, which should be respected. Above all doctors should never be judgmental about cultural patterns which differ from theirs.

Communicating with children should be developmentally appropriate. Communicating with a child using non-complex language can be a problem, which can be overcome by CS training.

Communicating with victims of abuse

When interviewing victims of sexual abuse, a victim-centred communication enables the victim to trust the doctor and facilitates obtaining the required information. This victim-centred approach is advocated in many protocols for sexual assault forensic examination²¹. In child sexual abuse greater skills are needed, not only to elicit a disclosure but also to commence the healing process by compassionate interviewing. In some countries, only those professionals especially trained in forensic interviewing skills obtain the history from the victim. In fact, some jurisdictions recognize the ability to communicate comfortably and effectively with children and their caregivers about sensitive issues as a prerequisite to conduct these forensic interviews of children²².

Communication Skills Training

While basic CS are expected of a newly qualified doctor, the same skills, at a higher level, are expected at postgraduate level, across all specialties. The acquisition of CS should be in a stepwise manner, acquiring knowledge early in undergraduate days, practicing such skills in the pre-clinical years and experience gained from real life consultations in the latter years. Once basic communication is mastered, complex and difficult consultations like the uncommunicative patient, depressed patient and aggressive patient will be further challenges to overcome.

Communication skills do not reliably improve after a mere one-time experience³. Therefore, undergraduate training should be complemented by advanced CS training in PG years and continued, after specialist status, at regular intervals¹³ as lifelong learning. In CS training of PG trainees in Forensic Medicine, the author observed that trainees who had received CS training as undergraduates were able to master the more specialized CS for forensic interviewing with ease. Therefore UG training in CS should be aligned with CS training in PG years with dialogue between UG and PG trainers.

Teaching-Learning Methods

Initially, students should acquire a knowledge of what constitutes effective CS. Students can move from simple guides developed from validated protocols¹⁰ to a more complete repertoire of CS²³ and faculty can use even more complex evidence-based protocols⁶ as the context demands.

Lectures to impart the basic principles of CS followed by demonstrations of recorded consultations with real or simulated patients (SP) are used in undergraduate education in many Faculties in Sri Lanka²⁰. Role play is also widely used, where three students play the roles of doctor, patient and assessor¹⁷. The players should rotate so that each undergoes the real life experience of all three roles. After a role play, de-roling or debriefing is also important. Role play during small group discussions are used in some Faculties including the Faculty of Medicine Colombo²⁰. This could be employed for postgraduate teaching, too, and the experience of these tutors could be utilized.

Observation of performance and feedback by an experienced tutor is the optimal method for teaching and assessment of CS²⁴. Direct observation of students during a real patient consultation with teachers' feedback on their CS, had the highest rating from undergraduate students from a study in Sri Lanka²⁵. However, for students to improve their CS, the ideal is to practice individually in a safe setting and receive feedback. Standardized patients are useful for this purpose. A standardised patient (SP) is simply a person who acts like a patient, but is trained so that each time he or she is interviewed, the same information is given accompanied with the same behavioral pattern. The advantage is that each trainee gets the same clinical scenario so that performance could be compared. For this purpose, an actor, or other skilled volunteers, could be used. The SP can give immediate feedback from the viewpoint of the patient to the trainee. However, since the SP should grasp the seriousness of the purpose and their importance in this process, they should be teachable and intelligent enough to give objective, constructive feedback. Therefore, selecting the right SP is a challenge.

Video recordings, with feedback, have proven to be the most effective teaching tool³ in some undergraduate programmes in Sri Lanka and has the advantage of evaluating body language too. Audio recordings and playback maybe used where the former is unavailable. These enable students to evaluate and correct their own mistakes. Guidelines should be followed by tutors^{17,26} when providing feedback. Feedback should be encouraging so that students would be motivated to learn.

Without training the trainers¹⁷ CS teaching is bound to be less effective. Clinicians in active practice and teaching who are excellent communicators, could be selected as role models. Teachers should also receive feedback on their performance as teachers of CS and as communicators¹⁷.

Assessing Communication Skills

Formative assessments are useful to encourage learning under nonthreatening, nonjudgmental conditions. The multisource feedback or peer team rating (PTR) introduced recently to PG programmes in Sri Lanka, which has a section on effective CS, could be an opportune intervention to obtain feedback from members of the healthcare team if implemented properly.

However, summative assessments are essential, as students may not study CS otherwise⁶. CS assessment in the ward setting was preferred above written tests by both undergraduate students and tutors, conforming to the global opinion²⁷. In fact, what is tested by written examinations may not reflect the true CS of a student, though they are still widely used due to

logistical and financial constraints. In many Faculties of Medicine, objective structured clinical examinations (OSCE) are used in clinical assessments to assess CS²⁷. OSCEs using standardized patients are a popular method of assessment and are currently used in some postgraduate specialist training in Sri Lanka. In the future, with the implementation of new curricula based on global standards, they could be used in other specialties as well.

Conclusions

Effective communication skills are a need in medical practice and are beneficial to patients, caregivers and doctors. CS can be learned and retained. The experience of faculty in teaching CS to undergraduates could be utilized for PG education as well, with proper alignment. Appropriate methods, more effective than lectures or written tests should be used for teaching and assessments respectively. Training of trainers will achieve better results.

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