Chapter 4: Reviewing communication skills

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The adverse effects of poor communication
What is good communication?
How do you assess communication?

"Doctors make mistakes, I know that – they're only human. And I wouldn't have minded, if only he'd said something – talked to me – even acknowledged it had happened."

The adverse effects of poor communication

You have to be blind, illiterate, or at best conservative to a reactionary degree, if you still think good communication is just the icing on the good clinical skills cake. It is much more than that: the evidence is unambiguous: poor communication by doctors reduces the effectiveness of medical treatment, leads to dissatisfaction in patient and doctor, and triggers complaints.

Stewart and others found patient-centred communication skills were associated with better recovery from symptoms and concerns, better emotional health scores, and fewer tests and referrals. They concluded that patient centred practice improved health status and increased the efficiency of care.[1]

Arora recently reviewed key findings linking physician communication behaviour with cancer patients' health outcomes and drew similar conclusions.[2]

The same team of investigators conducted three related RCT studies of the relationship between clinical communication and patients' health outcomes in chronic disease (ulcer disease, hypertension and diabetes). After enrolment, audiotape recordings of doctor – patient communication were obtained to provide baseline data. Communication was divided into 30 codes. Patient questionnaires, pain measures, blood pressure, and HbA1c measurements were obtained as outcomes. Patients were randomised to control and intervention (the latter were taught to ask more questions, seek more information and express themselves more fully). At follow up 6-12 months later there was a consistent relationship between changes in doctor-

patient communication and changes in health outcomes. Physiological and functional measures improved when patients were provided with more information about their problem, were able to show more emotion (especially ventilating negative emotion), and when they improved their effectiveness in eliciting information from doctors. Patients had worse outcomes with doctors who allowed patients less involvement in history taking , gave less information, and who expressed negativity. [3,4,5]

Seventy percent of litigation in the USA is related to poor communication: initiated by patients who feel they have been deserted, devalued, misunderstood, or have not been told everything.[6]

Bunting and others found that adverse outcomes, iatrogenic injuries, inadequate care, mistakes, incorrect care and system errors were unlikely to lead to litigation if there were no "predisposing" factors - like rudeness, delays, inattentiveness, miscommunication, apathy, or even no communication.[7]

What is good communication?

Which communication skills are critical in medical consultations?

Positive factors in the history-taking phase include doctors asking questions about patients' concerns, understanding, expectations, impact and feelings, doctors showing support and empathy, patients involved in full expression of their concerns, and patients' perception that there has been a full discussion. Positive factors in the management phase include patient information seeking and question asking, being successful in obtaining information, a willingness by the doctor to share decision making, agreement about the nature of the problems and the need for follow up.

When an error has occurred, patients want full disclosure ("truthfully and compassionately") of all harmful errors: to be told what happened, why, how the consequences will be mitigated, how recurrence will be prevented; they want an apology, and they need emotional support; they are upset, angry and scared. (Doctors want to disclose "truthfully, objectively, and professionally" but not when "harm is trivial, the patient cannot understand error, or does not want to know"; they want to "choose their words carefully", avoid stating an error has occurred, why, how it might be prevented, they worry an apology might create legal liability, are upset too, but don't know where to seek emotional support).[8]

These critical skills should be included when assessing practising doctors' communication. In its competence reviews, the Medical Council of New Zealand also emphasises the role of the lay as well as the professional assessor in assessing the doctor's communication at interviews, during the case based oral assessment, and while observing consultations.

How do you assess communication?

Defensible methods of assessing communication should reflect the considerable evidence concerning the validity and reliability of the assessment process.

The communication skills of practising doctors are usually assessed by standardised tests using (in rough order from least to most realistic) simulated patients in an objective structured clinical examination (OSCE) setting, direct observation in the practice, video analysis of real consultations by trained raters, and unannounced simulated patients (also known as "mystery shoppers").

Simulated or standardised patients are lay people or actors who are trained to portray a medical problem with a high degree of realism and accuracy. Simulated patient-based competence testing involves direct observation of the doctor's hands-on clinical behavior with such patients under standardised test taking conditions (the New Zealand College Primex clinical examination is a good example). The consultation is observed by an examiner, and marked on the spot. Simulated patients may also contribute to marking. Generalisability ratios (a measure of reliability) reach an acceptable level of 0.8 only with about 20 consultations (or about four to five hours of testing[9]), and more than one examiner – so to be done reliably the method requires a good deal of resource. The simulated patient consultations can be videotaped, but "assessment … of family physicians' practices by video observation in daily practice is superior to video assessment in a simulated setting using standardised patients".[10]

Direct observation involves assessing communication skills as part of an assessment visit, using a short evidence-based rating scale with numeric values and/or qualitative data. It is done in the context of the entire consultation, including diagnosis and management – and can be contrasted with competency testing (which examines discrete tasks). While patient consent can be an issue, there should be at least ten observed consultations. There is an "observer effect" which.may affect a doctor's usual behaviour – for better or worse! Global rating scales based on expert judgement are better than checklist scoring systems because the latter tend to trivialize the complex nature of the consultation. [11]

Videotaping of consultations in practice also stumbles at times on the issue of patient consent, but it is attractive because it is cheap, the doctor does the work, it examines encounters with real patients in context, the "observer effect" diminishes over time, quality control of raters is possible, the material is readily available for research, and "norms" can be determined with experience. The Royal Australian College of General Practitioners' (RACGP) Fellowship by Practice-based Assessment (PBA) requires 140 consultations (involving videotaping for over a week), with a logbook which takes about a minute per encounter. Two raters then view 15 consultations, selected from a blueprint to cover a range of clinical concerns, core knowledge, skills and attitudes, first-time and return visits, age and gender. Consultations are rated using a generic scale for history, diagnosis and management. There is a risk of selection bias by the doctor (this diminishes with large numbers of consultations), and there are still

issues around rating scales, consultation variation, "observer effect", patient consent, and the need for double cameras to allow for recording physical examination technique. Nonetheless, "Video assessment of GPs in daily practice according to the procedures described is a valid and reliable method, one which is useful for education and quality improvement. As always, there is a trade-off between feasibility on one hand and validity, reliability and credibility on the other hand".[12]

Mystery shoppers (unannounced simulated patients) have not been used by the Medical Council for performance assessment, but the method is well recognised.[13, 14] John O'Hagan, Calder Botting and Lanktree Davies were the first to report its use in New Zealand in 1989, after they had trained actors to simulate asthmatic patients on visits to Christchurch general practitioners - who had agreed beforehand to participate.[15] The doctors' performance is likely to be close to real life, a wide range of clinical scenes can be simulated, including those involving complex, difficult patients: more than one person at the consultation, cultural issues, mental health, and longitudinal care (an actor can visit the doctor more than once). Accurate recording of both communication and management advice is possible, and the degree of "patient centredness" measured by the actor; management can be assessed against predetermined standards based on evidence. Issues include concepts of the "use and abuse of deception[16]", the consent of the participating doctor, and the doctor mistakenly identifying a real patient as a simulator and "springing" them (though they are rarely detected[17]). The method is unreliable without rigorous selection and training of the actors, and it falls into disrepute when abused by news media trying to catch doctors behaving badly. The actor must be undetected, the scenario must fit to the practice, and processes in case of "detection" should be clear and agreed. Health insurance, billing, geography, address and phone can create difficulties. The actor has to be a "new patient" but can present more than once. There is significant cost in attaining the numbers of consultations needed to obtain reproducible results.

So what?

Remedial education in communication skills does work. You can teach an old dog new tricks, so the identification of poor communication skills can have a positive outcome for all. If a doctor has been the subject of complaint, and performance assessment shows poor communication skills, he (we use the pronoun advisedly, for "Female primary care physicians and their patients engage in more communication that can be considered patient centred and have longer visits than do their male colleagues"[18]) can learn to communicate more effectively. [19, 20, 21]

Conclusions

- Communication skill influences patient health outcomes and the likelihood of complaint;

- Performance based testing should critically appraise and build on those observations (content validity);
- Communication skill testing tools should be able to be applied in different testing situations (flexibility);
- Reliability depends on the size of the sample;
- Assessing communication skills is educationally sound because remedial education can improve communication skills.

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