

Why Clinical Communication Matters

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OVERVIEW

- The clinical interview is essential in collecting information about a patient and reducing diagnostic error.
- There is an evidence base for the skills that best facilitate collection of both the biomedical and psychosocial content of the patient's story.
- Good clinical communication underpins patient-centred care.
- Health professionals require continuing training in clinical communication in all its forms.
- Efficient information flow within the healthcare team is an essential component of patient safety.
- Respect for patients and colleagues is a prerequisite for effective clinical communication.

Clinical communication – a historical perspective

In the absence of defined physical examination methods and investigations, such as blood tests and imaging, interviewing the patient was the mainstay of diagnosing illness and managing disease. While we know little of the format of the doctor–patient encounter prior to the nineteenth century, *listening* was a virtue associated with the competent doctor. The doctor relied on the patient's description of symptoms to make a diagnosis. As only wealthier members of society could afford the services of a doctor, good communication skills were rewarded with greater employment. The apprenticeship model of medical training led to the role-modelling of these skills by senior doctors. While the doctor–patient relationship has evolved since then (see Figure 1.1), the 'history' remains the most important means of making a diagnosis.

Improving knowledge of anatomy, physiology and the pathological basis of disease during the 1800s contributed to a structured clinical method consisting of a structured history and physical examination (see Box 1.1). William Osler, sometimes described as 'the father of modern medicine', took students from the lecture theatre to the patient's bedside so that students could talk to patients

about their experience of disease and physically examine them for signs of the illness.

Even in an era of rapid change in the scientific basis of medicine, Osler's maxim to his students was: '*Listen to your patient; he is telling you the diagnosis.*' In modern times, the history alone accounts for around 80% of diagnoses. Strikingly, increasing availability of diagnostic technology (e.g. laboratory tests and imaging) has not substantially altered this percentage.

It is worth considering what the healthcare professional wishes to derive from the patient interview or encounter. The purpose is to:

- Correctly diagnose the patient's illness.
- Avoid diagnostic error.
- Give the patient effective and appropriate treatment.
- Achieve the patient's adherence to treatment.
- Cure or mitigate the effect of the illness.
- Improve the patient's health status.
- Communicate care, concern and empathy.

Early studies of the consultation correlated the quality of the interview directly with the quality of clinical data collected (see 'Further resources'). An open-ended approach with the intention of allowing patients to identify problems of concern identified those problems well. The failure of professionals to allow patients to complete an opening statement during the consultation and an over-controlling approach (e.g. using closed questions) directly reduced the quality of information.

Poor-quality information results in a predisposition to diagnostic error, and the term 'clinical hypocompetence' has been used to describe this (see Box 1.2). While a biomedical perspective has contributed to improvements in diagnosis, the use of a solely biomedical approach risks being reductionist as it fails to take account of the patient's own experience, context and wishes. The power imbalance between the 'all-knowing' professional and the passive patient contributes to poorer outcomes. The post-war era saw the development of societal concepts such as greater self-determination, autonomy, gender rights and equality. This influenced healthcare as well, with the result of the model of the consultation we have today (see Chapter 2).

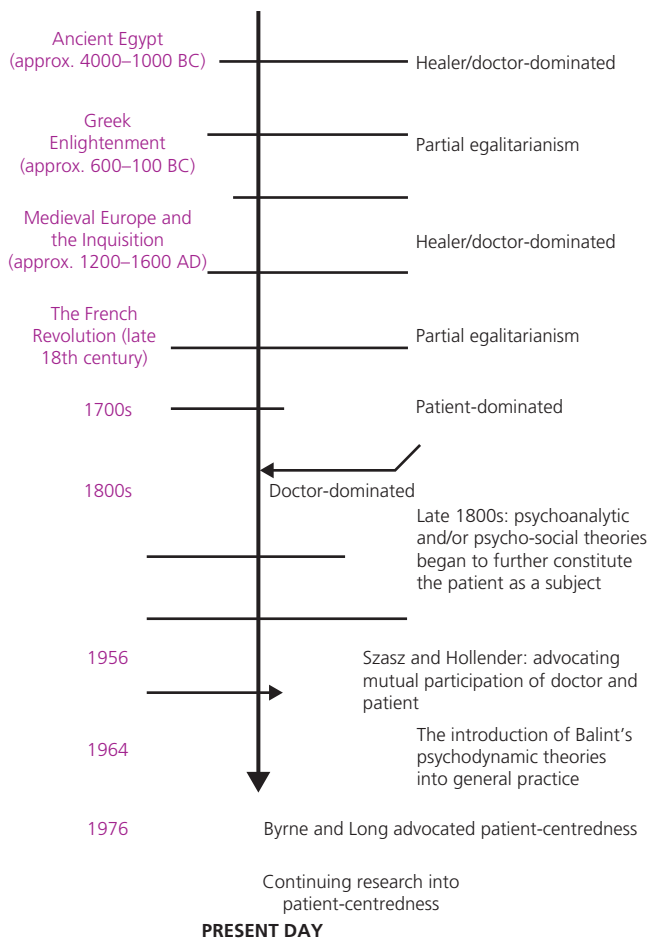


Figure 1.1 Evolution of the doctor–patient relationship. *Source:* Kaba and Sooriakumaran (2007). Reproduced with permission of Elsevier.

Box 1.1 The traditional model of a structured patient history

- Demographics
- Presenting problem(s)
- History of presenting problem(s)
- Past medical history
- Systems enquiry
- Family history
- Medications and allergies
- Social history

Source: Adapted from Stoeckle and Billings (1987). Reproduced with permission of Springer.

Even for the same illness, no two patients are going to give identical stories. Each will have a different experience of their symptoms and different concerns about their significance. Obeying Osler's maxim to *listen* requires seeing the patient's perspective and their own unique experience. If we needed to update Osler to make this clearer, we might say: '*Listen to your patient and see the illness through his eyes; he is telling you the diagnosis.*'

Box 1.2 Clinical hypocompetence in the medical interview

Physician-engendered defects in the interview are due to one or a combination of:

- Lack of therapeutic intent
- Inattention to primary data (symptoms)
- A high control style
- An incomplete database usually omitting patient-centred data and active problems other than the present illness
- A thoughtless interview in which the physician fails to formulate needed working hypotheses

Source: Adapted from Platt and McMath (1979). Reproduced with permission of American College of Physicians.

The emergence of a bio-psychosocial-cultural model placed emphasis not only on *what was the matter with the patient* but also, as Engel (1977) famously described, *what mattered to the patient*. This evolved further into one that enabled patients to fulfil their potential and ultimately into 'patient-centred medicine' in which the patient has to be understood as a unique human being. This approach has been endorsed by patients and professional and regulatory bodies across the world and much research has explored the factors influencing patient-centredness (see Figure 1.2).

Patient-centred care entails involvement in discussion of treatment options and decision-making, as well as sharing of information, including records (see Chapter 4). Shared decision-making improves patient and professional satisfaction with the consultation. It involves a common acceptance of the problem, discussion of the available management options, including their benefits and risks, eliciting the patient's own views and preferences for these options and then agreeing on a management plan.

In some respects, we have proceeded forward to the past as the evidence supports the wisdom of Osler's advice. Research has identified the skills that best determine important biomedical and psychosocial data and thus facilitate diagnosis. Over the last 40 years we have developed an evidence base for clinical communication associated with higher patient satisfaction. Several consultation models have been developed which form the basis of undergraduate and postgraduate training (see Box 1.3). We consider one of these models in Chapter 2. Barriers to its successful implementation include a continuing strong emphasis on the biomedical perspective with its doctor-centredness, time pressures and lack of ongoing appropriate training.

Educational interventions to teach good communication skills have been evaluated and accepted as good practice. All UK medical schools now provide training in communication. The use of simulated patients and models of feedback are also accepted as the norm in many training programmes. Teaching clinical communication is discussed in more detail in Chapter 10. The European Association for Communication in Healthcare has defined the learning objectives in a proposed core curriculum across all the health professions (Box 1.4).

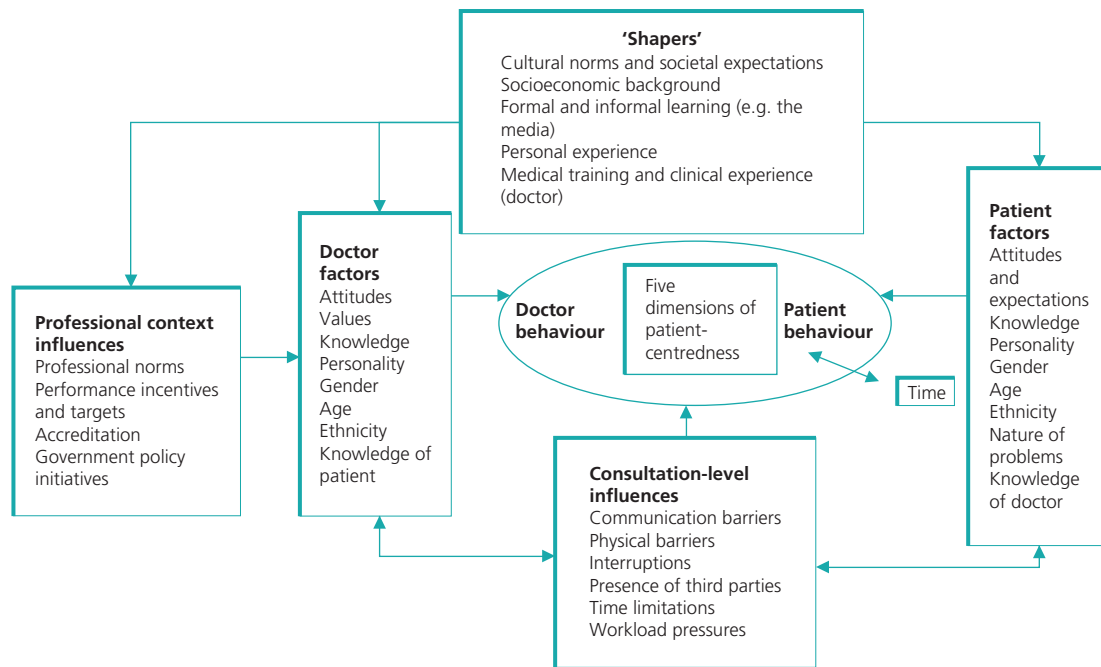


Figure 1.2 Factors influencing patient-centredness. Source: Mead and Bower (2000). Reproduced with permission of Elsevier.

Box 1.3 Models of the consultation

Established models include:

- Patient-centred clinical method (Brown *et al.*, 1986)
- Three function model (Bird & Cohen-Cole, 1990)
- E4 model (Keller & Carroll, 1994)
- Calgary-Cambridge guide (Silverman *et al.*, 1998)
- Patient-centred interviewing (Smith *et al.*, 2000; Fortin *et al.*, 2012)
- Four habits (Frankel & Stein, 2001)
- SEGUE framework (Makoul, 2001)

Source: Adapted from Brown *et al.* (2016). Reproduced with permission of Wiley.

Effect of communication on patient outcomes

Improved interviewing, information-sharing and shared decision-making contribute to improved patient outcomes, particularly in chronic disease. There are reduced levels of patient discomfort and concern.

Patients perceive communication within the interview as a marker of quality. It is related to patient satisfaction, adherence to treatment, litigation, quality of data collection, patterns of use of services and clinical outcomes. Those behaviours associated with higher patient satisfaction are displayed in Figure 1.3.

Much has been achieved in the last 30–40 years and improvements in clinical communication are being implemented worldwide. Nonetheless, there remain a series of challenges if the actuality of patient-centred care is to be developed further. In addition to identifying relevant skills and factors affecting patient-centredness, research has also identified the adverse impacts on patient and

Box 1.4 Domains for a health professions core curriculum: objectives for undergraduate education in health care professions.

- Communicating with patients
 - Core skills
 - Shaping of relationship
 - Patient's perspective and health beliefs
 - Information-sharing
 - Reasoning and decision-making
 - Dealing with uncertainty
- Intra- and interpersonal communication (professionalism and reflection)
 - Communication with self and others
 - Dealing with errors and uncertainty
- Communication in health care team (professional communication)
 - Teamwork and professional communication
 - Leadership
 - Professional communication and management

Source: Adapted from the European consensus. Reproduced with permission of Elsevier.

staff well-being of poor communication. Each of these provides significant challenges for health services in the twenty-first century (see Box 1.5)

Training and feedback

Communication is one of the health professional's core skills. Patients place great value on quality of communication. To fulfil Osler's maxim, students need to be observed practising integration of both biomedical and psychosocial perspectives in the

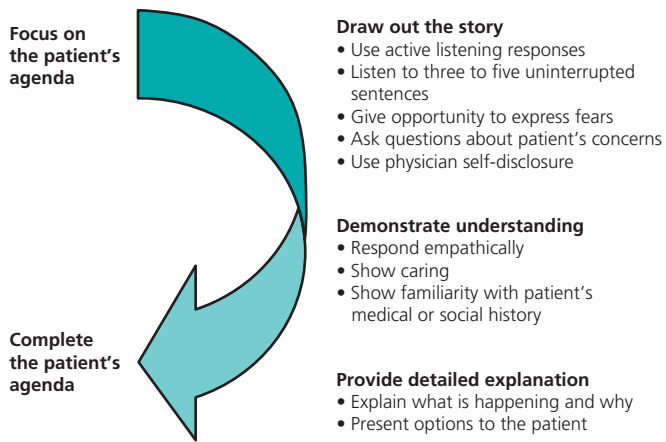


Figure 1.3 Model of behaviours linked to higher patient satisfaction.

Source: Tallman *et al.* Reproduced with permission of *Permanente Journal*.

Box 1.5 Impact of poor communication in healthcare

Poor communication in healthcare has an impact on the following aspects of patient care:

- Diagnostic accuracy
- Adherence to treatment
- Patient satisfaction
- Patient safety
- Team satisfaction
- Malpractice risk

consultation. While pre-qualification training includes communication, it is relatively rare for postgraduate trainees to receive instruction once qualified. While there is emphasis on improving one's knowledge after qualification, there exists little opportunity for direct observation and feedback on existing skills or the acquisition of new communication skills. Health professionals may not realise the possibility or need to improve their communication skills post-qualification. There is too often the assumption that these skills will automatically improve through exposure and experience, even though qualified health professionals are responsible for more complex communication tasks such as shared decision-making or breaking bad news, for which they may have had limited training as students. Continuing professional development and reflection on communication skills should not be dependent solely on receipt of adverse feedback or need for remediation. A core 'curriculum' for reflection on personal communication skills for significant events, appraisal or relicensing is suggested in Box 1.6. Clinical communication in more complex consultations is covered in Chapters 7–9.

It is in the interest of a healthcare provider to ensure there is development of clinical communication skills among its workforce. System-wide, relationship-centred training has a measurable impact on patient satisfaction scores. A further benefit is improved physician empathy, self-efficacy and reduced physician burnout. Short-term training (i.e. < 10 hours) is as successful as longer training. Courses can involve video or direct observation, debrief and feedback and group work involving role-play. Organisation-wide

Box 1.6 Domains for reflection in advanced clinical communication

- Responding to and managing own emotions
- Opportunistic promotion of health
- Managing uncertainty
- Shared decision-making
- Enabling self-care
- Responding to a complaint
- Candour and disclosure of medical error
- Communication within a multidisciplinary team

programmes of clinical communication training are effective when there is adherence to a single model, strong leadership and role-modelling, and outcomes include satisfaction of the professionals in training as well.

Communication between professionals

Clinical communication is not just about clinician and patient. Ineffective communication within and between teams contributes to over two-thirds of clinical errors. Healthcare professionals require skills not only to elicit clinical data in each encounter with a patient but also to efficiently convey this information to fellow professionals. Shared records can assist here (e.g. in maternity, child development, heart failure) but it is important that there is also consistency of terminology and sharing of information across different professional groups. An example is the discharge summary written from the perspective of one professional group (e.g. the doctor) and not including information from another group also extensively involved with care (e.g. allied health professionals). Lack of physician–nurse record integration of information in a Dallas hospital in 2015 led to a patient with the Ebola virus being sent home inappropriately, and the incident made international news. Trainees in all health professions require education, training and evaluation of their handovers, both verbal and written, to improve patient safety.

The Francis report into the Mid-Staffordshire NHS Foundation Trust identified the ward round as key to good co-ordination of patient care. The nursing team was identified as 'a central point of communication between the patient and medical staff'. Also highlighted in the report were full and comprehensive handovers between shifts, involving members of the multidisciplinary team. Consideration should be given to the timing of ward rounds to maximise participation by all those involved with the patient's care, including the carer and/or the family. Equally, staff should recognise attendance at ward rounds and participation in handovers as being a priority in facilitating clinical communication. Communication within teams is discussed in more detail in Chapter 5.

Written records

The importance of a clear, contemporaneous record is emphasised by professional bodies and accepted as good, safe practice. Deficiencies in written records are related to errors. However,

acquisition of this basic skill is not always reflected in training programmes. Review and audit of clinical records are not established elements of appraisal, meaning that suboptimal record-keeping often emerges only when things go wrong. Perhaps more than oral communication, written records are learned through trial and error and are dependent on the role-modelling of senior staff. Similarly, the discharge summary is a crucial piece of communication between the hospital and community services. The quality of discharge summaries is related to clinical workload. Interventions providing teaching and practice of note-keeping and preparation of discharge summaries followed by feedback do improve the abilities of trainees and should be incorporated into core clinical communication training. Defining standards for discharge summaries is also effective. Communication in medical records is discussed in more detail in Chapter 6.

A caring environment

Good clinical communication cannot be commanded or coerced. It is related to an individual's personal characteristics (see Chapter 3) but can also be taught and improved. A stressful, overloaded working environment inhibits effective clinical communication and puts patients at risk. Good organisational management and leadership facilitate good communication, promote job satisfaction and reduce staff turnover. Staff members reporting job satisfaction are more likely to build rapport with patients and display empathy and concern.

Rudeness and incivility can impair clinical performance. Three sources of rudeness have been identified in the healthcare environment:

- hierarchical rudeness – originating from someone in authority;
- peer rudeness – from a colleague;
- client rudeness – enacted by a patient, family member or friend.

All sources of rudeness have the same effect on performance of the recipient. The Francis report also highlighted the attitudes prevalent among staff as contributing to the adverse outcomes for patients found in the hospital. A randomised controlled trial in a simulated neonatal intensive care unit examining the effect of mild rudeness on diagnostic and procedural tasks found that rudeness alone accounted for 12% of the variance between intervention and control groups. This variance increased once information-sharing and help-seeking were accounted for in the analysis. This suggested an effect of incivility on the communication within the intervention team. Composite diagnostic and procedural performance scores were lower for teams exposed to rudeness than for members of control teams.

Conclusions

Communication with patients has always been a key element of the diagnostic process, and it remains so. Good communication underpins the physician–patient relationship (see Box 1.7). An open approach in which patients can describe in detail what is happening to them and what concerns them is important. It is not only a question of determining what is wrong with the patient but also what matters most to the patient. This is facilitated by

Box 1.7 The physician–patient relationship

'To attend those who suffer, a physician must possess not only the scientific knowledge and technical abilities, but also an understanding of human nature. The patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust. The importance of an intimate relationship between patient and physician can never be overstated because in most cases an accurate diagnosis, as well as an effective treatment, relies directly on the quality of this relationship.'

Source: From Hellin (2002). Reproduced with permission of Wiley.

listening and learning to see things the patient's way. It is important for healthcare professionals to understand there is an evidence-base for the skills to achieve this and it is important for teachers to define learning objectives to teach these. There remain challenges in making health services truly patient-centred and further research is required to decide which interventions best achieve safe and patient-centred care. Effective information flow within and between healthcare teams is a particular challenge, and training in written communication needs to be given greater priority. Poor communication has a direct effect on patient care. The working environment, including the level of mutual respect and civility, is fundamental to clinical communication between all staff and their patients.

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Further resources

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