

Key communication skills and how to acquire them

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Good doctors communicate effectively with patients—they identify patients' problems more accurately, and patients are more satisfied with the care they receive. But what are the necessary communication skills and how can doctors acquire them?

When doctors use communication skills effectively, both they and their patients benefit. Firstly, doctors identify their patients' problems more accurately.¹ Secondly, their patients are more satisfied with their care and can better understand their problems, investigations, and treatment options. Thirdly, patients are more likely to adhere to treatment and to follow advice on behaviour change.² Fourthly, patients' distress and their vulnerability to anxiety and depression are lessened. Finally, doctors' own wellbeing is improved.³⁻⁵ We present evidence that doctors do not communicate with their patients as well as they should, and we consider possible reasons for this. We also describe the skills essential for effective communication and discuss how doctors can acquire these skills.

Sources and selection criteria

We used original research studies into doctor-patient communication, particularly those examining the relation between key consultation skills and how well certain tasks (such as explaining treatment options) were achieved. We used key words ("communication skills," "consultation skills," and "interviewing skills" whether associated with "training" or not) to search Embase, PsycINFO, and Medline over the past 10

Box 1: Key tasks in communication with patients

- Eliciting (a) the patient's main problems; (b) the patient's perceptions of these; and (c) the physical, emotional, and social impact of the patient's problems on the patient and family
- Tailoring information to what the patient wants to know; checking his or her understanding
- Eliciting the patient's reactions to the information given and his or her main concerns
- Determining how much the patient wants to participate in decision making (when treatment options are available)
- Discussing treatment options so that the patient understands the implications
- Maximising the chance that the patient will follow agreed decisions about treatment and advice about changes in lifestyle

Summary points

Doctors with good communication skills identify patients' problems more accurately

Their patients adjust better psychologically and are more satisfied with their care

Doctors with good communication skills have greater job satisfaction and less work stress

Effective methods of communication skills training are available

The opportunity to practise key skills and receive constructive feedback of performance is essential

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years. We also searched the Cochrane database of abstracts of reviews of effectiveness (DARE).

Deficiencies in communication

Box 1 shows the key tasks in communicating with patients that good doctors should be able to perform. Unfortunately, doctors often fail in these tasks. Only half of the complaints and concerns of patients are likely to be elicited.² Often doctors obtain little information about patients' perceptions of their problems or about the physical, emotional, and social impact of the problems.⁶ When doctors provide information they do so in an inflexible way and tend to ignore what individual patients wish to know. They pay little attention to checking how well patients have understood what they have been told.² Less than half of psychological morbidity in patients is recognised.⁷ Often patients do not adhere to the treatment and advice that the doctor offers, and levels of patient satisfaction are variable.^{2, 8}

Reasons for deficiencies

Until recently, undergraduate or postgraduate training paid little attention to ensuring that doctors acquire the skills necessary to communicate well with patients.

Doctors have therefore been reluctant to depart from a strictly medical model, deal with psychosocial issues, and adopt a more negotiating and partnership style.^{2 6} They have been loath to inquire about the social and emotional impact of patients' problems on the patient and family lest this unleashes distress that they cannot handle. They fear it will increase patients' distress, take up too much time, and threaten their own emotional survival. Consequently, they respond to emotional cues with strategies that block further disclosure (box 2).⁹

Box 2: Blocking behaviour

- Offering advice and reassurance before the main problems have been identified
- Explaining away distress as normal
- Attending to physical aspects only
- Switching the topic
- "Jolly" patients along

Even if doctors have the appropriate skills, they may not use them because they are worried that their colleagues will not give sufficient practical and emotional support if needed.¹⁰ Doctors may also not realise how often patients withhold important information from them or the reasons for this (box 3).⁹

Box 3: Reasons for patients not disclosing problems

- Belief that nothing can be done
- Reluctance to burden the doctor
- Desire not to seem pathetic or ungrateful
- Concern that it is not legitimate to mention them
- Doctors' blocking behaviour
- Worry that their fears of what is wrong with them will be confirmed

Skills needed to perform key tasks

Eliciting patients' problems and concerns

Establish eye contact at the beginning of the consultation and maintain it at reasonable intervals to show interest.¹¹ Encourage patients to be exact about the sequence in which their problems occurred; ask for dates of key events and about patients' perceptions and feelings. This helps patients to recall their experiences, feel understood,¹² and cope with their problem.

Use "active listening" to clarify what patients are concerned about⁹—that is, respond to cues about problems and distress by clarifying and exploring them.¹¹ But avoid interrupting before patients have completed important statements.¹³

Summarise information to show patients they have been heard, and give them an opportunity to correct any misunderstandings.⁹ Inquire about the social and psychological impact of important illnesses or problems on the patient and family¹⁴; this shows the patient that you are interested in his or her psychosocial wellbeing, and that of the family.

Giving information

Check what patients consider might be wrong and how those beliefs have affected them.¹⁵ Ask patients what

information they would like, and prioritise their information needs so that important needs can be dealt with first if time is short.⁹ Present information by category—for example, "you said you would like to know the nature of your illness." Check that the patient has understood before moving on.¹⁶

With complex illnesses or treatments, check if the patient would like additional information—written or on audiotape. However, if you have to give the patient a poor prognosis, providing an audiotape may hinder psychological adjustment.

Discussing treatment options

Properly inform patients of treatment options, and check if they want to be involved in decisions. Patients who take part in decision making are more likely to adhere to treatment plans.² Determine the patient's perspective before discussing lifestyle changes—for example, giving up smoking.²

Being supportive

Use empathy to show that you have some sense of how the patient is feeling ("the experiences you describe during your mother's illness sound devastating"). Use educated guesses too. Feed back to patients your intuitions about how they are feeling ("you say you are coping well, but I get the impression you are struggling with this treatment"). Even if the guess is incorrect it shows patients that you are trying to further your understanding of their problem.

How to acquire the skills

Effective training methods

Box 4 lists the teaching methods for helping doctors to acquire relevant communication skills and stop using blocking behaviour.^{1 17} These methods have been used in undergraduate and postgraduate teaching.^{18 19} A "good" doctor, wanting to audit and improve his or her skills, should ensure that any course or workshop they attend includes three components of learning: cognitive input, modelling, and practice of key skills.

Box 4: Effective teaching methods

- Provide evidence of current deficiencies in communication, reasons for them, and the consequences for patients and doctors
- Offer an evidence base for the skills needed to overcome these deficiencies
- Demonstrate the skills to be learned and elicit reactions to these
- Provide an opportunity to practise the skills under controlled and safe conditions
- Give constructive feedback on performance and reflect on the reasons for any blocking behaviour

Cognitive input

Courses should provide detailed handouts or short lectures, or both, that provide evidence of current deficiencies in communication with patients, reasons for these deficiencies, and the adverse consequences for patients and clinicians. Participants should be told about the communication skills and changes in attitude that remedy deficiencies and be given evidence of their usefulness in clinical practice.



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Modelling

Trainers should demonstrate key skills in action—with audiotapes or videotapes of real consultations. The participants should discuss the impact of these skills on the patient and doctor.

Alternatively, an “interactive demonstration” can be used. A facilitator conducts a consultation as he or she does in real life but using a simulated patient. The interviewer asks the group to suggest strategies that he or she should use to begin the consultation. Competing strategies are tried out for a few minutes then the interviewer asks for people’s views and feelings about the strategies used. They are asked to predict the impact on the patient. Unlike audiotaped or videotaped feedback of real consultations, the “patient” can also give feedback. This confirms or refutes the group’s suggestions. This process is repeated to work through a consultation so that the group learns about the utility of key skills.

Practising key skills

If doctors are to acquire skills and relinquish blocking behaviour, they must have an opportunity to practise and to receive feedback about performance. However, the risk of distressing and deskilling the doctor must be minimised.

Practising with simulated patients or actors has the advantage that the nature and complexity of the task can be controlled. “Time out” can be called when the interviewer gets stuck. The group can then suggest how the interviewer might best proceed. This helps to minimise deskilling. In contrast, asking the doctor to perform a complete interview may cause the doctor to lose confidence because “errors” are repeated.

Asking doctors to simulate patients they have known well and portray their predicament makes the simulation realistic. It gives doctors insights into how patients are affected by different communication strategies.

For a simulation exercise to be effective, doctors must be given feedback objectively by audiotape or videotape.¹⁹ To minimise deskilling, clear ground rules should be followed:

- Positive comments should be offered about what strategies (oral and non-oral) were liked and why

- Constructive criticism should be allowed only after all positive comments have been exhausted
- Participants offering constructive criticisms should be asked to suggest alternative strategies and give reasons for their suggestions
- Any blocking behaviour should be highlighted and the interviewer asked to consider why it was used (including underlying attitudes and fears)
- The group should be asked to acknowledge if they have used similar blocking behaviour and why
- To reinforce learning, the doctor should be asked to reflect on what he has learned, what went well, and what might have been done differently.

Context of learning

Some doctors feel safer learning within their own discipline.²⁰ Others welcome the challenge of learning with those from other disciplines, such as nursing²¹; multidisciplinary groups enable doctors to understand and improve communication between disciplines. The relative merits of these two different environments has still to be determined.

Doctors are more likely to attend workshops or courses in communication skills if they know that substantial time will be devoted to their own agenda. Thus, they should be asked to identify the communication tasks they want help with. These will commonly include the tasks discussed already plus more difficult situations, such as breaking bad news, handling anger, and responding to difficult questions.

Limiting the size of the group to four to six participants creates the sense of personal safety required for participants to disclose and explore relevant attitudes and feelings. It also allows more opportunity to practise key communication tasks.²²

Facilitators who have had similar feedback training are more effective in promoting learning than those who have not.²³ Residential workshops lasting three days are as effective as day workshops lasting five days.²¹ Whether longer courses are more effective than workshops plus follow up workshops needs to be determined.

Using new skills in practice

Practising communication skills with simulated patients leads to the acquisition of skills and the relinquishing of blocking behaviour. However, doctors do not transfer these learned skills to clinical practice as comprehensively as they should.²⁴ Offering doctors feedback on real consultations should ensure more effective transfer of skills.

Access to training

Sources of information

- Administrators of postgraduate centres
- Advertisements in professional journals

Well established courses

- Medical Interview Teaching Association, London
- Cancer Research UK Psychological Medicine Group, Manchester
- Cancer research UK Psycho Oncology Group, Brighton

Current evidence suggests that the good doctor who attends short residential workshops or courses to improve his or her skills and then has an opportunity to receive feedback about how he or she communicates in real consultations will learn most. Doctors will find that both they and their patients benefit. Patients will disclose more concerns, perceptions, and feelings about their predicament, will feel less distressed, and be more satisfied. Doctors will feel more confident about how they are communicating and obtain more validation from patients.

Good doctors will wish to continue their learning over time by self assessment (recording their own interviews and reflecting on them) or attending further courses or workshops.

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The good doctor around the world

What do medical traditions around the world have to say about the necessary qualities of the “good doctor”? Two Sanskrit texts that form the basis of ayurveda (the Indian Hindu medical tradition) state that students embarking on an apprenticeship to become a vaidya (an ayurvedic physician), must vow to respect patients and be abstemious, modest, courteous, and self controlled. They must also make a concern for the health of sick people their sole aim. In textual sources for unani tibb, the Graeco-Arabic medical tradition practised in South Asia, ideal qualities of the hakim (an unani physician) include compassion, restraint, probity, moderation, self restraint, humility, and lack of ambition (other than to do good). In ayurveda, unani, and traditional Chinese medicine, doctors should aid the needy and treat the sick without discriminating on grounds of wealth or background. These classical traditions also expect their practitioners to continue their self education so that they improve learning and technical skills; knowledge and expertise are valued in most medical systems worldwide.

Although UK patients value knowledge and technical ability, communication and being listened to is similarly highly rated. By contrast, in rural Rajasthan, India, patients regard the ability of a doctor to diagnose their ills by taking their pulse without the need for them to speak as the sign of a truly good physician. Practitioners of siddha medicine, a South Indian Tamil therapeutic tradition based on the writings of Hindu yogis, also claim to learn everything about a patient's internal state just by feeling the pulse.

A theme found in most medical traditions and therapeutic practices worldwide is that healing abilities involve special wisdom

and insight. In many traditions, such powers are couched in a religious or metaphysical idiom, but there are clear resemblances to the “special,” “extra” qualities cited as characteristic of the good doctor among the *BMJ*'s respondents to the question of what is a good doctor in this week's letters section. Across cultures special healing powers are also often associated with the potential to do harm. In northern India, for example, the *sayana bhopa* (“wise and cunning priest”) can kill through sorcery as well as heal. Again, analogous fears exist over the negative potential of Western biomedicine's power, evidenced in the growing concerns over malpractice and in attempts at regulation. The dark side of biomedical healing is most sinisterly expressed in the archetypal spectre of the British general practitioner and mass murderer Harold Shipman.

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We welcome articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.