Communication – the heart of the consultation

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Communication – the heart of the consultation

Presentation outline

• Introduction
• Definitions
• Short history of HCP-Pt communication
• Characteristics of communication
• Hindrances of communication
• Own study on HCP-Pt communication
• Conclusion
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Introduction

“The patient is not just a group of symptoms, damaged organs and altered emotions. S/he is a human being, … who is searching for relief, help and trust.”

The accuracy of the diagnosis, as well as the effectiveness of the treatment directly depends on the quality of the provider-patient relationship.”

(Hellin, 2002)
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Definition

• **Communication** is a way in which humans make sense of the world around them.

• It takes place as an **interactive two-way process or interaction**, involving two or more people and can occur by verbal, non-verbal, face-to-face or non-face-to-face methods.

• It plays an integral role in **service quality** in all service professions including health care professions.

Newell & Jordan, 2015
“Effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which is the heart and art of medicine.”

Ha & Longnecker, 2010
A contribution to the philosophy of medicine; the basic models of the doctor-patient relationship.

SZASZ TS, HOLLENDER MH.

PMID: 13312700

1. The model of activity-passivity
   • The doctor in total control of the situation
   • Entirely paternalistic in nature, (parent-infant relationship)

2. The model of guidance-cooperation
   • The HCP placed in a position of power.
   • The patient is ready and willing to “cooperate”, (parent-adolescent relationship)

3. The model of mutual participation
   • Interaction of “equal partners”
   • based on the belief that equality amongst human beings is mutually advantageous
We are challenged to provide **quality care**, with the following characteristics:
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• The quality of provider–patient communication has been associated with:
  • Increased patient adherence to treatment (Zolnierek & Dimatteo, 2009)
  • Increased procedural uptake e.g. cancer screening (Carcaise-Edinboro & Bradley, 2008)
  • Improved blood pressure control in hypertensive patients (Orth et al., 1987)
  • Reductions in the risk of serious medical error (Kuzel et al., 2004).
Effective communication skills:

• Building rapport
• Asking more open-ended questions
• Establishing eye contact (cultural sensitivity)
• Exploring patient’s health beliefs
• Listening more, talking less
• Complementing effort & legitimising patient’s views and feelings
• Expressing empathy
• Probing for patient’s understanding
• Summarising what the patient said (reflective summaries)
• Clarifying patient’s expectations
• Exploring patient’s family and social factors (biopsychosocial)

Tailored communications:

• Breaking Bad News
• Brief Behavioural Change Counselling (MI)
• Trauma Debriefing

Meta-analysis (Zolnierek & Dimatteo, 2009)
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**The patient-centred approach**

Characterised by:

- Biopsychosocial perspective
- The ‘patient-as-person’
- Shared power and responsibility
- The therapeutic alliance
- The ‘doctor-as-person’

Mead and Bower, 2000
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If all these attributes of patient-centeredness are to be covered, how much time does a quality consultation require?

• A study on the duration of ambulatory visits to GPs covering 19,192 consultations with 686 GPs revealed that the average duration of consultations was 16 min (Blumenthal et al., 1999).

• It lasted longer for patients with psychosocial problems or those with 4 or more diagnostics (71% increase) (Blumenthal et al., 1999).

• It was found to last shorter for follow-up consultations (Deveugele et al., 2002).
Consultation length in general practice: cross sectional study in six European countries
Myriam Deveugele, Anselm Derese, Atie van den Brink-Muinen, Jozien Bensing, Jan De Maeseneer

Table: Length of consultation with general practitioner

<table>
<thead>
<tr>
<th>Country</th>
<th>Mean (SD) time (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>7.6 (4.3)</td>
</tr>
<tr>
<td>Spain</td>
<td>7.8 (4.0)</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>9.4 (4.7)</td>
</tr>
<tr>
<td>Netherlands</td>
<td>10.2 (4.9)</td>
</tr>
<tr>
<td>Belgium</td>
<td>15.0 (7.2)</td>
</tr>
<tr>
<td>Switzerland</td>
<td>15.6 (8.7)</td>
</tr>
<tr>
<td>Overall</td>
<td>10.7 (6.7)</td>
</tr>
</tbody>
</table>
How much time does a quality consultation require? (Cont.)

- The average patient visiting a doctor in the USA was found to be allowed 22s for his/her initial statement, and then the doctor took the lead (Langewitz, 2002).

- If they simply allowed their patients to say whatever they had to say, the mean spontaneous talking time was found to be 92s (Blumenthal et al., 1999).

**Implication:** Allowing the patient to talk without interruption tends to focus the consultation and saves time (Poot, 2009).
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**Determinants of the length of a consultation**

- **Urban vs. rural practices**
  - Longer in cities by 1.5min

- **Patient’s age**
  - An age increase by 1 year – 1sec increase in consultation time

- **Psychosocial problems**
  - As perceived by the Dr on the Pt & in women

- **New consultations vs. follow-ups**
  - New consultations longer

Deveugele et al., 2002
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Determinants of the length of a consultation

• Doctors’ characteristics (studies differ regarding age & sex)
  • However, female doctors tend to be preferred by patients because of their socialisation which they bring into their professional lives (care, warmth, patience & love (Gray, 1982).

• Patients’ characteristics
  • Longer for women vs. male pts & increasing age

• Doctors’ workload
  • The more the workload, the lesser the consultation time

Deveugele et al., 2002
Time management in a consultation

The HCP needs to be structured

- About 49yrs ago, Lawrence Wood developed a system of problem orientated medical record (Lawrence, 1969).
- This subsequently gave birth to the SOAP system (Kettenbach, 2003).
- Subjective – gives patient (an expert in own experience) the opportunity to inform you.
- Objective – provider applies knowledge and skills to understand the patient’s experience scientifically.
- Assessment – provider attaches a label to his/her findings, traditionally known as the diagnosis.
- Plan – provider & patient negotiate the management
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Time management in a consultation

Take note:

• Regarding assessment (diagnosis) patient satisfaction was found to be higher with physicians who admitted being uncertain about the diagnosis, who informed the patient that they required to verify it (Gordon, 2000).

• The hand-on-the-door syndrome can be noted and be deferred to a subsequent consultation (Poot, 2009).

• The never-ending patient?
  • Be honest and usher the patient out gently (Poot, 2009)

• Doctors with good communication skills experience fewer difficult consultations (8% vs. 23%) (Poot, 2009)
Barriers in a consultation

As expressed by patients

- Related to provider’s behaviour:
  - “not reacting with empathy to my concerns”
  - not explicitly inviting patient to discuss their condition
  - “Giving me the feeling that I am stupid when I express my concerns”
  - Provider responding defensively to patient’s questions & queries.

- Related to the environment
  - Provider does not have time to listen to my concerns
  - Provider constantly looking at his/her computer screen

- Legitimacy barriers
  - Fear that “I am wasting my provider’s time”
  - Fear to sour relationships if perceived a nuisance.

Brandes et al., 2014
The effect of unmet expectations among adults presenting with physical symptoms.

**Jackson JL, Kroenke K.**

15% of the consultations were described as **difficult**.

### HCP’s Perspective
- Pts with **psychiatric** problems
- Suffered from **over 5 somatic symptoms**
- With **severe symptoms**

### Patient’s Perspective
- **Expectations** had not been met
- **Dissatisfied** with the consultation
- Regarded themselves as excessive consumers (**burdensome**).
Poor communication effects

A significant proportion of malpractice claims are driven by poor communication

Tamblyn et al., 2007; Vincent et al., 2006
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Mabuza et al. BMC Health Services Research (2015) 15:89

RESEARCH ARTICLE Open Access

Inpatients’ awareness of admission reasons and management plans of their clinical conditions at a tertiary hospital in South Africa

Langalibalele H Mabuza¹, Olufemi B Omole², Indiran Govender¹, John V Ndimande¹ and Herman S Schoeman³
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<table>
<thead>
<tr>
<th>Variable</th>
<th>OR, 95% CI</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (≤40 versus &gt; 40 years)</td>
<td>1.18 (0.67 – 2.09)</td>
<td>0.57</td>
</tr>
<tr>
<td>Marital status</td>
<td>0.96 (0.53 – 1.73)</td>
<td>0.89</td>
</tr>
<tr>
<td>Educational level</td>
<td>1.13 (0.30 – 4.36)</td>
<td>0.33</td>
</tr>
<tr>
<td>Employment status</td>
<td>0.79 (0.44 – 1.39)</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Mabuza et al., 2015
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Mabuza et al., 2015

### Table 2 Respondents’ global awareness on all aspects of health care

<table>
<thead>
<tr>
<th>Global awareness</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>128</td>
<td>48.5</td>
</tr>
<tr>
<td>Yes</td>
<td>136</td>
<td>51.5</td>
</tr>
<tr>
<td>Total</td>
<td>264</td>
<td>100</td>
</tr>
</tbody>
</table>

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Figure 3: Proportions of patients seeking clarity on the various aspects of health care.

Mabuza et al., 2015
Reasons for inpatients not to seek clarity at Dr George Mukhari Academic Hospital, Pretoria

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Background: Healthcare practitioners should provide patients with information regarding their clinical conditions. Patients should also feel free to seek clarity on information provided. However, not all patients seek this clarity.

Objectives: To explore the reasons inpatients gave for not seeking clarity on information that was received but not understood.


Mabuza et al., 2014
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Reasons for inpatients not to seek clarity

<table>
<thead>
<tr>
<th>A. Healthcare practitioner-related themes</th>
<th>B. Patient-related themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Healthcare practitioners were perceived to be too busy</td>
<td>1. Notion that healthcare practitioners held patients in low esteem</td>
</tr>
<tr>
<td>2. Experiences of bad treatment</td>
<td>2. Incapacitating clinical condition</td>
</tr>
<tr>
<td>3. Patients forbidden to ask questions</td>
<td>3. No reason for not asking</td>
</tr>
<tr>
<td>4. Healthcare practitioners were perceived to be aloof from patients</td>
<td>4. Patients’ fear of bad news</td>
</tr>
<tr>
<td>5. Unquestioning trust in health care practitioners</td>
<td>5. Patients already knew their conditions</td>
</tr>
<tr>
<td>6. Language barrier</td>
<td>-</td>
</tr>
<tr>
<td>7. Healthcare practitioners were feared by patients</td>
<td>-</td>
</tr>
<tr>
<td>8. The healthcare practitioner appeared uncertain about the patient’s condition</td>
<td>-</td>
</tr>
</tbody>
</table>

Mabuza et al., 2014
“The patient will never care how much you know, until they know how much you care.”

Terry Canale, 2000
Institute of Medicine Committee on Quality of Health Care in America: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC, National Academy Press, 2001


Maguire P., Pitceathly C. Key communication skills and how to acquire them. BMJ. 2002;325((7366)):697–700. [PMC free article] [PubMed]


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References


