Doctor-Patient Communication

Introduction to series

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Of all the tools in your kit, the interview is undoubtedly the one you use most often. In fact, if your practice is like that of most general practitioners, you will conduct some 5000 interviews in the coming year[1] and spend about 1250 hours talking with your patients.

You might think, quite rightly, that nothing comes more naturally than talking and that you do not need special training to communicate with patients. In fact, to attain the objectives of professional communication, you probably have to make changes to your personal style. Communication skills can be learned and can be used to great effect. They are the focus of this new series.

Training is limited

Since the shift to greater reliance on technology in medicine and until quite recently, interview training generally comprised just giving young physicians a list of questions to ask their patients. Once they had memorized it, they developed their individual communication skills through trial and error. The method proved its worth over time, and most experienced clinicians were able to develop their approach by transposing skills learned in everyday life to clinical consultations. While most physicians manage quite well, they probably could communicate better. Both patients and communication specialists agree that there is room for improvement.[2]

Although communication training programs have improved since the 1980s, especially in family medicine residency programs, more progress can be made. The importance of communication with patients is now generally acknowledged, but during residency, the focus is on acquisition of other skills. In medical circles (particularly in hospitals), training in interview techniques and patient-physician communication still has a strong "psychosocial" connotation and is considered less relevant to the work of physicians.

Notable outcomes

Observational studies have demonstrated that effective communication influences certain outcomes of care.[3-5] Problems identified by physicians have greater congruence with those reported by patients; patients are more compliant with recommendations; patients recall information better; monitoring of physiologic variables, such as blood-pressure and blood-sugar levels, is improved; patients are less anxious; and patients and physicians are more satisfied with visits.[6]

Quality of information

The quality of the information physicians gather in consultations is closely related to their ability to question patients and establish relationships with them. Between 60% and 80% of the information needed to arrive at a diagnosis in primary care is obtained during patient interviews.[7,8]

Every student of communication knows that effective interviewing relies on techniques that are both flexible and systematic. Experienced clinicians

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also know how important it is to elicit information that is as complete and accurate as possible. The methods for achieving these goals are known, have been systematized, and can be learned, so while being a born communicator is an asset, it is definitely not a requirement.

In the articles in this series, we will illustrate a particular perspective both on communication and on physician-patient relationships. We will identify the characteristics of such relationships so that physicians can use them as a guide to action. In discussing communication, we will therefore also deal with relationships between patients and physicians. We want to do more than just help you communicate better with your patients. We want to help you develop better relations with them.

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The medical interview

Setting, nonverbal language, and social roles

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A paper on medical interviews or doctor-patient communication might be expected to start with an examination of the first words a patient and a physician speak to each other. Communication experts tell us, however, that the words people exchange are only one element in a complex system of communication.[1] A great deal of information is also derived from the physical context of the discussions, the social roles of participants, and the clues provided by their clothing and nonverbal behaviour. Before delving into conversations between patients and physicians, therefore, we look at the setting in which their exchanges take place.

Physical context and the message it conveys

Communication between patients and physicians begins long before they actually say anything to each other; their behaviour is informed and influenced by the physical context in which the dialogue takes place.[2] We can grasp the effect of physical context if we look first at professional communication outside usual hospital or clinical settings and think of the wealth of information physicians on house calls gather about patients before a single word is spoken. The neighbourhood and its surroundings, the type of dwelling and its