EDITORIAL

Medical communication: a core medical competence

Katarzyna Jankowska[1], Tomasz Pasierski[2]

1 Department of Pediatric Hematology and Oncology, Nicolaus Copernicus University, Ludwik Rydygier Collegium Medicum in Bydgoszcz, Bydgoszcz, Poland
2 Department of Bioethics and Medical Humanities, Warsaw Medical University, Warsaw, Poland

Introduction At the beginning of the 21st century, patient-centered medicine has emerged as the field focusing on the improvement of patient satisfaction with medical care and medical outcomes.[1] Studies in many countries have confirmed that the increasing dissatisfaction with medical care is largely related to communication problems.[2,3] Communication is one of the most common and important activities in medical practice, but, paradoxically, it has received relatively little attention in medical education so far.[4]

The health consumer movement and patients' rights advocacy have led to the current model of shared decision making and to patient-centered communication. For centuries, the concept of patient-centered medicine has been neglected in clinical practice. The majority of physicians avoided delivering bad news to patients for fear of destroying their hope. Historically, the model of the physician–patient relationship has always been dependent on the medical situation of the patient and the social scene. Physicians and patients' ability of self-reflection and communication as well as any technical skills are embodied in the medical situation of the patient. The social scene refers to the sociopolitical and intellectual and scientific climate of the time. Nowadays, the model of the physician–patient relationship has evolved from paternalism to partnership that is fundamental to the idea of patient-centered medicine.

Positive health outcomes of effective communication in medicine For the past 30 years, the effects of communication interventions have been rigorously tested in the same way as one may study the effects of a new drug on a diseased population.[5-8]

There is substantial evidence that doctor–patient communication has the potential to facilitate comprehension of medical information, and allows for better identification of patients' needs, perceptions, and expectations.[1,5-8] Patients reporting good communication with their doctors are more satisfied with their care. Opportunities exist for providers to improve patients' understanding of their disease and its treatment and to tailor interventions based on whether patients are intentionally or unintentionally nonadherent. It is often stated that there is a strong correlation between the sense of control and the ability to tolerate pain, recover from illnesses, and improve daily functioning.[9]

Physicians with better communication skills can detect problems earlier, identify patients' problems more accurately, prevent medical crises, and provide better care to their patients.[10]

Communication skills and the quality of medical care Effective communication between patients and their health-care providers has been shown to improve the perceived quality of care.[1] Patients today regard themselves as health consumers and want to be active participants in medical decision-making. Patients' agreement with physicians about the nature of the treatment is strongly associated with their recovery.[1] Patients tend to leave doctors who failed to involve them in making decisions.[7]

Most complaints about doctors are about the lack of communication rather than clinical competency. Effective doctor–patient communication is associated with a lower probability of lawsuits in the event of an adverse outcome.[8] Patients appreciate physicians who can skillfully diagnose and treat their illnesses as well as communicate effectively. Physicians with good communication skills have more job satisfaction, less work stress, and are less prone to burnout. Patient-centered practice improved health status through perceptions that common ground was achieved and increased the efficiency of care by reducing diagnostic tests and referrals.[9]

Correspondence to:
Prof. Tomasz Pasierski, MD, PhD, Zakład Bioetyki i Humanistycznych Podstaw Medycyny, Warszawski Uniwersytet Medyczny, ul. Żwirki i Wigury 81, 02-081 Warszawa, Poland, phone/fax: +48-22-473-53-12, e-mail: tpasierski@mssw.pl
Received: May 22, 2014.
Revision accepted: May 23, 2014.
Published online: May 30, 2014.
Conflict of interest: none declared.
Pol Arch Med Wewn. 2014; 124 (7-8): 350-351

Communication skills training Doctor–patient communication is a procedural skill, which may be systematically taught and evaluated.[10,11] Clinical communication skills do not improve merely from experience.[10] Many doctors, especially those clinically experienced, tend to overestimate their communication skills.[1] Unfortunately, traditional medical education at all levels has not dealt with teaching clinical communication.[10] Recently teaching communication skills has become an essential element of the medical school curriculum in most European countries, United States, and Canada.[10-12] A significant step toward defining the methods for teaching communication skills was made in 2003 by a group of 16 medical education leaders from medical schools worldwide, participating in the 2003 Harvard Macy Institute Program for Physician Educators. The expanded communication competencies and teaching strategies were summarized in the consensus of the American College Graduate Medical Education (ACGME) for competency in communication skills.[12]

The accepted examples of comprehensive models that have been used in many countries for teaching and training are the Maastricht History-Taking and Advice Checklist, the Calgary–Cambridge Guides, the Four Habits Model, and the Practical Guide to Teaching and Assessing the ACGME Core Competencies. The European consensus for teaching medical communication has also been proposed.[11]

To maintain the effects of training, it is important to teach communication in the real-life setting. Otherwise learners are confronted with 2 apparently conflicting models of the medical interview: a communication model describing the process of the interview and the "traditional medical history" describing the content of the interview. The Calgary Cambridge model bridges these 2 approaches.[13]

In Poland, the current curricula of medical education put more emphasis on general and medical psychology rather than on professional communication training.[14] The analysis of the curricula used at the faculties of medicine unequivocally indicate that the scope of education in professional medical communication is very narrow, and, with a few exceptions, there are no modules dedicated directly to this topic.[14] Currently, there is a strong need for incorporating teaching communication into the curricula of medical schools in Poland. According to the current regulations, curricula are established independently by each medical faculty, so this issue needs to be addressed by each medical faculty and each university individually.

Conclusions The ultimate objective of doctor–patient communication is the same as that of medicine—to improve the patient's health. Communication skills are not something additional to medical practice but are a core clinical competence of a physician.

The implementation of modern knowledge about communication into the curricula of medical schools and clinical practices will improve the relationship between the patient and physician and increase the efficiency of medical care.

REFERENCES

1 Stewart M, Brown JB Weston WW, et al. Patient Centered Medicine. Transforming the clinical method. 2nd ed. Abingdon, United Kingdom: Radcliffe Medical Press; 2003.

2 Roter DL, Hall JA. Doctors talking with patients/Patients talking with doctors. Westport, Connecticut: Auburn House; 1992.

3 DiMatteo MR. The role of the physician in the emerging health care environment. West J Med. 1998; 168: 328-333.

4 Henry SG, Holmboe ES, Frankel RM. Evidence-based competencies for improving communication skills in graduate medical education: A review with suggestions for implementation. Med Teach. 2013; 35: 395-403.

5 Stewart MA. Effective physician-patient communication and health outcomes: a review. Can Med Assoc J. 1995; 152: 1423-1433.

6 Williams S, Weinman J, Dale J. Doctor-patient communication and patient satisfaction: a review. Fam Pract. 1995; 15: 480-492.

7 Greenfield S, Kaplan S, Ware JE. Expanding patient involvement in care: effects on patient outcomes. Ann Intern Med. 1985; 102: 520-528.

8 Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician--patient interactions on the outcomes of chronic disease. Med Care. 1989; 27 (Suppl 3): S110-S127.

9 Suchman AL, Roter D, Green M, Lipkin M Jr. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993; 31: 1083-1092.

10 Simpson M, Buckman R, Steward M. Doctor-patient communication: the Toronto consensus statement. BMJ. 1991; 303: 1385-1387.

11 Bachmann C. A European consensus on a core communication curriculum for health care professions. Patient Educ Couns. 2013; 18: 157-165.

12 Rider EA, Keefer CH. Communication skills competencies: definitions and a teaching toolbox. Med Educ. 2006; 40: 624-629.

13 Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. Acad Med. 2003; 78: 802-809.

14 Wołoszczak-Szubzda A, Jarosz MJ. Selected aspects of a professional doctor-patient communication—education and practice. Ann Agric Environ Med. 2013; 20: 373-379.