

Physician Communication Skills: Results of a Survey of General/Family Practitioners in Newfoundland

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Purpose: To describe the attitudes related to communication skills, confidence in using communication skills, and use of communication skills during the physician-patient encounter among a population-based sample of family physicians.

Procedures: A mailed survey, distributed to all family physicians and general practitioners currently practicing in Newfoundland. The questionnaire was designed to collect data in five general areas—participant demographics, physician confidence in using specific communication strategies, perceived adequacy of time spent by physicians with their patients, physician use of specific communication strategies with the adult patients they saw in the prior week, and physician use of specific communication strategies during the closing minutes of the encounters they had with adult patients in the prior week.

Main Findings: A total of 160 completed surveys was received from practicing family physicians/general practitioners in Newfoundland, yielding an adjusted response rate of 43.1%. Most of the respondents (83.8%) indicated their communication skills are as important as technical skills in terms of achieving positive patient outcomes. Between one-third and one-half of the respondents, depending on the educational level queried, rated their communications skills training as being inadequate. Fewer than 20% of the respondents rated the communications skills training they received as being excellent. Physicians indicated a need to improve their use of 8 of 13 specific communication strategies during patient encounters, and reported using few communication strategies during the closing minutes of the encounter. Interactions that occurred during a typical encounter tended to focus on biomedical versus psychosocial issues.

Conclusions: Family physicians/general practitioners recognize a need to improve their communications skills. Well-designed communications skills training programs should be implemented at multi-levels of physician training in order to improve patient satisfaction with their encounters with family/general practitioners, and to increase the likelihood of positive patient outcomes.

It has been almost a decade since a consensus meeting in Toronto concluded that, "Sufficient data have now accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management."¹ Available data indicate the quality of doctor-patient communication has a significant impact on patient satisfaction,² medical outcomes,^{3,4} medical costs, and even the likelihood of a physician experiencing a malpractice claim.⁵ Patient satisfaction with physician communication is not, however, a straightforward issue. For example, the expectations patients

have regarding their receipt of non-technical interventions such as education have been shown to affect their level of satisfaction with an encounter⁶ as do their perceptions of tension expressed by their physician.⁷ Patient satisfaction appears to be enhanced when the patient and the physician have a similar orientation regarding their respective roles during an encounter.⁸

In recent years particular interest has focused on examining the closing moments of the encounter. For example, studies have found that patients identify

new problems in over 20% of the closing moments of an encounter, and physician interruptions occur in more than one-third of these discussions.^{12,13} The impact of these events on patients' satisfaction with the encounter is likely to be negative. The well-documented problems that occur with doctor-patient communication^{14,15} are still a concern. For example, Levinson and Chaumeton¹⁶ reported that patient encounters with surgeons in an ambulatory setting were characterized by discussions that had a narrow biomedical focus with little attention being paid to the psychological aspects of the patient's problem, and by the surgeons talking more than the patients. This is consistent with the findings of a study involving patient encounters with primary care physicians. In this study patients were more satisfied with a visit when their physician had a communication pattern that was dominated by psychosocial versus biomedical issues. Interestingly, physicians also expressed dissatisfaction when the communication pattern during a patient encounter was dominated by biomedical issues.¹⁷ Similar findings were found in a study involving outpatient cancer patients. This study found that physicians seldom focused their discussions on patients' psychological concerns, used closed versus open-ended questions, and provided patients few opportunities to initiate discussions important to them.¹⁸ The lack of a focus on the patient's agenda is demonstrated in a study involving family physicians in which patients' attempts to express their concerns to their physician were completed in only 28% of encounters, with the physician interrupting the patient within an average of 23 seconds from the start of the conversation.¹⁹ These concerns may be even more problematic with elderly patients as evidenced by the results of a study that found physicians were more informative and supportive with younger patients, and were more condescending with elderly patients.²⁰ Finally, if there is poor interpersonal interaction or communication between the patient and physician (particularly the "usual source of care" physician) the patient is more likely to use the emergency department rather than the usual source of care physician. This will tend to increase system costs given that the emergency department is the most expensive/costly delivery setting. For example, Weinkauff and Kralj show that the average visit costs of providing care in the ER are more than one-third higher than in the office or walk-in clinic settings.²¹

However, well-designed interventions can improve the communication skills of physicians,^{22,23} and a number of initiatives directed at improving their communication skills have been initiated throughout Canada.²⁴ It is probable that the effectiveness of

these and other educational efforts could be improved if we had a greater understanding of physicians' attitudes towards various aspects of the doctor-patient communication, if we had an assessment of physicians' confidence in using specific communication strategies, and if we were more aware of what communication strategies physicians routinely use in their encounters with patients and what their expectations of using these strategies were. The purpose of this study was to expand and refine our knowledge with regard to these issues as they pertain to general/family practitioners encounters with adult patients.

Methods

A three-step process was used to develop the survey instrument. First, the published and grey literature was reviewed to identify the concepts that have been used to characterize physician communication skills as well as the methods used to assess these skills.²⁵ The second step involved the conduct of interviews and focus groups with practicing physicians with the intent of verifying the results of the literature review and identifying additional concepts of effective patient communication. An instrument was then developed based on the identified concepts underlying physician communication skills. The third step involved having the instrument reviewed by a panel of experts, and pre-testing it with 40 general/family practitioners.

The resulting instrument included five sections: demographics (e.g., number of patients seen in a typical clinical day); confidence in using communication strategies (e.g., How confident are you in your ability to successfully identify and pursue verbal cues given by your patient?); time spent with patients (e.g., In your conversations with the adult patients you saw last week, how often was the focus of your conversation on biomedical issues directly related to the health problem?); use of communication strategies (e.g., In recalling the adult patients you saw last week, in what percent of these patients did you actively encourage them to express their feelings about their current problem?); and, closing the encounter (e.g., In recalling the adult patients you saw last week, during the closing minutes of the encounter, in what percent of these patients did you summarize what had occurred during the encounter?).

Generally, the respondents completed the questions by selecting the response option that "most accurately reflects" their answer to the question. For example, when asked to respond to the question, "How confident are you in your ability to success-

fully use each of the following communication strategies with all or almost all of your adult patients?”, respondents could select among four options: “Confident: I don’t really need to improve”; “Confident: but believe I need to improve”; “Not very confident: believe I need to improve”; “not very confident: not a priority to improve.” Some of the questions were structured as four-point scale questions (e.g., 1 - “most of the time”; 2 - “some of the time”; 3 - “a little of the time”; 4 - “none of the time”). Respondents were also asked to estimate the percentage of their adult patients with whom the respondent used different communication strategies (if applicable). Communication strategies were presented to the respondents, and they were asked to rank their importance (among nine strategies from 1 to 9, where 1 represented the most important in terms of patient outcomes and 9 the least important).

The Newfoundland and Labrador Medical Association (NLMA) reviewed the project and formally endorsed its implementation among practicing physicians in Newfoundland and Labrador. A mailing list of all practicing physicians in Newfoundland and Labrador was obtained from the NLMA. This list included 379 general/family practitioners. In January, 2000, all the general/family practitioners on the list were sent a survey package that included an introductory letter on Health Canada letterhead that indicated the purpose of the survey and its endorsement by the NLMA, the survey instrument and a stamped pre-addressed envelope in which to return the completed survey. The entire survey package was re-sent to non-responders at four and seven weeks following the initial mailing. Returned surveys were reviewed to determine the overall completion rate. Surveys were excluded from analysis if fewer than 50% of the survey items were completed. The survey responses were coded and entered into a database. To verify the quality of the data entry process, the actual responses for every 10th survey were compared to the responses that had been entered into the database. This activity uncovered no errors in the data entry process. The survey data were then analyzed using the Statistical Analysis System (SAS), version 8.0 software.

Findings

We received 160 completed surveys from general/family practitioners yielding a response rate of 42.2%. However, since eight of the surveys were unable to be delivered by the mail service, the adjusted response rate was 43.1%. This rate is similar to rates reported in other studies involving physicians in Canada.^{26,27} The respondents were predominately

established (in practice an average of 16.9 years) male physicians (74.4%) who worked in busy practices (seeing an average of 33.1 patients/day) that were located in rural (51.3%) and urban/suburban areas (46.9%).

While all respondents reported having received some type of communications skills training, it was judged to be an insufficient amount of training at the undergraduate (50.0%) and residency (36.9%) levels as well as in the time since completion of their residency (30.6%). Irrespective of where the physician respondents received their communications skills training, fewer than 20% judged it to be excellent.

As a measure of self-efficacy, respondents were asked to comment on their confidence to use various communication strategies during encounters with most or the majority of their adult patients. More than half the respondents indicated they were confident in and didn’t need to improve their use of two of the 13 identified communication strategies (i.e., conveying empathy—57.5% and explaining treatment options—51.3%). However, for eight of the 13 communication strategies a majority of the respondents indicated they believed they needed to improve their use of the strategy.

Respondents identified communication strategies they felt they most needed to improve. The communication strategies they wanted to improve were: communicating effectively with difficult patients (83.7%); securing patient commitment to follow the treatment plan (76.9%); discussing alternative or complementary therapies (75.7%); identifying and pursuing non-verbal patient cues (73.2%); and, identifying and pursuing verbal patient cues (68.1%). Interestingly, among these communication strategies physicians differed in their confidence in using the strategy. For example, while 75.7% of respondents indicated they needed to improve their ability to discuss alternative or complementary strategies with their patients, 44.4% expressed confidence in their current abilities to use the strategy while 31.3% indicated they were not very confident (Table 1). Finally, the vast majority (83.8%) of respondents indicated that their communication skills were as important as their technical skills in terms of achieving desirable patient outcomes.

While most of the physicians (63.1%) reported they had been able to spend the required amount of time with the patients they saw during the prior week, 23.8% indicated the time spent with their patients was insufficient. Almost two-thirds of the physicians (62.5%) stated that most of the time spent with their

patients was devoted to discussions of biomedical issues. Discussion of psychosocial issues was most likely to consume some of the time (67.5%) or a little of the time (13.8%) during a typical patient encounter.

Physicians were asked to estimate the frequency with which they used specific communication strategies with the adult patients they saw in the previous week (Table 2). While all of the strategies were reported as having been used with the patients they saw during the prior week, a majority of the physicians indicated they used 11 of the 13 strategies with more than 60% of their patients. The strategies they most frequently used were: addressing patients in a polite, warm friendly manner (92.6%); addressing patient questions at the appropriate level of detail (84.4%); responding to patients who express their feelings in a supportive manner (81.9%); and educating patients about treatment options and checking for their understanding (76.3%). The two strategies physicians did not use in more than 60% of their patient encounters were: actively encouraging patients to express their feelings about their problem (57.6%), and determining the psychological, emotional and social needs of their patients (52.5%). It is interesting to note that while the respondents indicated that all of the communication strategies contributed significantly to positive patient outcomes, the contribution of these strategies to outcomes was greater for new versus established patients. For example, respondents indicated that actively expressing understanding and empathy for their patients' problems significantly contributed to positive patient outcomes more frequently with new (91.3%) than with established (79.4%) patients.

Physicians were also asked to estimate the frequency with which they used nine specific communication strategies during the closing minutes of their patient encounters during the previous week (Table 3). Only three of the communication strategies were used by a majority of the physicians with more than 60% of their patients: reviewing the treatment plan with patients (59.4%); encouraging patients to follow the plan and reassuring them that it should help to resolve the problem (57.5%); and, informing patients what to expect as the condition gets worse or better (50%). The physicians were also asked to rank the nine communication strategies in terms of their contribution to a positive patient outcome. The strategies ranked as being most important were: summarizing what occurred during the encounter; asking patients if they understand the nature of the problem and the components of the treatment plan; and reviewing the treatment plan. The strategies ranked as being least

important were: referring patients to support services; expressing concern for patients' resolution of their problems; and informing patients the encounter is ending.

Discussion

The results of this survey are instructive regarding the need for and desired direction of physician communication initiatives. The physician respondents generally rated their prior communication skills training as being insufficient in quantity and only acceptable to poor in quality. They also indicated a need to improve their use of eight of the 13 communication strategies that were identified on the survey. Thus, for example, the respondents indicated a need to improve their ability to identify non-verbal patient cues, to discuss alternative and complementary therapies with patients, to address their patients' psychosocial needs, and to secure a commitment from patients to try to adhere to the agreed-upon treatment plan. This suggests that these primary care physicians are at a stage of readiness where they are likely to respond to initiatives to help them expand and improve their communication skills. What is crucial, therefore, is to ensure that the communication skills initiatives that are offered to primary care physicians are designed in accord with what has been shown to be effective. The importance of this point is illustrated in a review of 14 studies on communication skills training for nurses in which it was concluded that communications training had limited or no effects on nurses' communication skills as well as on their use of these skills in a working environment.²⁸

Well-designed communications skills training sessions for physicians, however, have been shown to have a significant impact on their acquisition of communication skills, on refinement of their existing skills, and on their patterns of using these skills in clinical settings. For example, a one-day interactive training program offered to physicians in a health maintenance organization was effective in increasing participants' confidence in their ability to use specific communication skills as well as their self-reported use of communication skills at a three-month follow-up. This training program focused on specific strategies to use during the medical interview, on strategies useful for brief encounters, and on managing difficult patient interactions.²⁹ A shorter communications training program (i.e., 4½ hours) was also able to demonstrate changes in physicians' acquisition and subsequent use of specific communication skills. A communications training program directed at primary care residents was effective in altering the structure of the consultation, in increasing the use of a patient-

centered communication style and in involving patients in decision-making. This training differs from others in that it involved short training sessions (totaling 22½ hours) distributed over a six-month period.³¹ Even brief workshops (i.e., four hours) that address topics as sensitive as how to deliver bad news and how to deal with difficult situations in the practice of oncology have been shown to result in an increase in the acquisition of communications skills and participants' self-reported confidence in using them during clinical encounters.³² Two characteristics seem to be associated with successful communications skills training programs: they are interactive in nature and they focus on specific communications skills. Even though interactive learning is a basic tenet of adult learning, its application in physician training programs, especially CME programs, is far from being universal. The selection of which communication skills to focus on during a training session should be based on the self-assessed or demonstrated needs of the participants. Guidance in the selection of which specific communication skills are most important comes from Roter, who has identified five conceptual groupings of physician-patient communications skills: information-giving, question-asking, partnership-building, rapport-building, and socio-emotional talk.³³ Any one of these categories could be the focus of a communications training initiative. The results of our study and others suggest certain foci of communications training may be especially important at this time. For example, the findings by Marvel and associates³⁴ that patients are interrupted, on average, 23 seconds after initiating the conversation, and only 28% of their concerns were fully expressed to their physician, strongly suggest the need for a focus on active listening skills. If physicians are not good listeners, it is unlikely that they will be good communicators.

Given that the time spent with patients appears to be decreasing, the need for physicians to learn how to be effective listeners increases in importance. Our results indicate that physicians did not routinely encourage their patients to express their feelings about their problems, and did not routinely determine the psychological, emotional and social needs of their patients. Addressing these topics often requires more time than addressing biomedical topics and is very much dependent upon the physician's active listening skills. The development of these skills should be a priority within most communications training programs, as should training in how to address psychosocial issues in an efficient and effective manner. Our results also indicate a need to focus training on increasing physicians' confidence (i.e., personal self-efficacy) in their use of specific communications

skills. Bandura defines the concept of self-efficacy as a person's assessment of her/his ability to take an action.³⁵ A person must perceive herself or himself to be capable of taking the desired action in order to initiate the sequence of steps required to bring that action about.³⁶ With regard to physicians, this can best be done with interactive training sessions combined with feedback from actual patient encounters. This could involve videotaping patient encounters, use of simulated patients, patient questionnaires or a combination of the above.^{37,38}

Finally our data suggest that the closing moments of the encounter represent a special training opportunity. Physicians report using only a few communication strategies during the closing moments and do not routinely use two strategies that they rated as being of high importance—i.e., summarizing what occurred during the encounter, and asking patients if they understand the nature of their problem and the components of their treatment plan.

While it is encouraging that interest in communications skills training for physicians is increasing in North America, it is sobering to note how far we appear to be lagging behind the United Kingdom. In the UK a national effort was initiated in the early 1990s to develop a strategy to assess the interpersonal skills of general practitioners against a set of clearly defined performance criteria (e.g., the doctor encourages the patient's contribution at appropriate points in the consultation). To receive a post graduate qualification in family medicine physicians must submit 15 videotaped consultations for review by trained video examiners, and attain a passing mark.³⁹ Ideally, communications skills training will attain a similar level of importance in North America at the undergraduate, graduate and post-graduate training levels by the end of the first decade of this new century.

The findings and observations of this study must be interpreted in light of its limitations. The attitudinal, self-efficacy and behavioral communications skills data are self-reported by respondents. This is the most appropriate method for collecting the attitudinal and self-efficacy data, but an observational method is a more rigorous procedure for collecting data on actual use of communication strategies. It seems reasonable to assume the behavioral data overestimate the actual use of the communication strategies. In addition, while the response rate is similar to that reported in other studies involving physicians, it is still less than ideal. This concern is somewhat offset by the fact that the survey was population-based, involving all family physicians/general practitioners

in Newfoundland. Finally, since we do not know how respondents differ from non-respondents, it seems reasonable to assume that the respondents are more interested in the topic of physician-patient interactions.

Conclusion

Physician-patient communications skills are integral to patient satisfaction, optimal use of time during the patient-provider encounter, patient participation in treatment decision-making, adherence to the treatment plan, and positive patient outcomes. Physicians recognize the importance of good communication skills, but require training to ensure effective delivery. There is an urgent need for coordinated approaches to facilitate communication skills training at the undergraduate, residency and post-graduate levels.

References

1. Simpson M, Buckman R, Stewart M, et al. Doctor-patient communication: the Toronto consensus statement. *BMJ* 1991;303:1385-87.
2. Wiggers JH, Donovan KO, Redman S, et al. Cancer patient satisfaction with care. *Cancer* 1990;66:610-16.
3. Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. *Ann Intern Med* 1985;102:520-28.
4. Stewart MA. Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 1995;152:1423-33.
5. Levinson W, Roter DL, Mullooly JP, et al. Physician-patient communication: The relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 1997;277:553-59.
6. Brody DS, Miller SM, Lerman CE, et al. The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Med Care* 1989;27:1027-35.
7. Carter WB, Inui TS, Kukull WA, et al. Outcome-based doctor-patient interaction analysis: II. Identifying effective provider and patient behavior. *Med Care* 1982;XX:550-66.
8. Krupat E, Rosenkranz SL, Yeager CM, et al.

The practice orientations of physicians and patients: the effects of doctor-patient congruence on satisfaction. *Patient Educ Counsel* 2000;39:49-59.

9. Rowland-Morin PA, Carroll JG. Verbal communication skills and patient satisfaction: A study of doctor-patient interviews. *Eval Health Prof* 1990;13:165-85.
10. Roberts CS, Cox CE, Reintgen DS, et al. Influence of physician communication on newly diagnosed breast patients' psychologic adjustment and decision-making. *Cancer* 1994;74:336-41.
11. Wiggers JH, Donovan KO, Redman S, et al. Cancer patient satisfaction with care. *Cancer* 1990;66:610-16.
12. White J, Levinson W, Roter D. "Oh, by the way...". The closing moments of the medical visit. *J Gen Intern Med* 1994;9:24-28.
13. White JC, Rosson C, Christensen J, et al. Wrapping things up: A qualitative analysis of the closing moments of the medical visit. *Patient Educ Couns* 1997;30:155-65.
14. Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. *Ann Intern Med* 1984;101:692-26.
15. Richards T. Chasms in communication. *BMJ* 1990;301:1407-8.
16. Levinson W, Chaumeton N. Communication between surgeons and patients in routine office visits. *Surgery* 1999;125:127-34.
17. Roter DL, Stewart M, Putnam SM, et al. Communication patterns of primary care physicians. *JAMA* 1997;277:350-56.
18. Ford S, Fallowfield L, Lewis S. Doctor-patient interactions in oncology. *Soc Sci Med* 1996;42:1511-19.
19. Marvel MK, Epstein RM, Flowers K, et al. Soliciting the patient's agenda: Have we improved? *JAMA* 1999;281:283-87.
20. Adelman RD, Greene MG, Charon R. Issues in physician-elderly patient interaction. *Ageing Society* 1991;11:127-48.
21. Weinkauff DJ, Kralj B. Medical service provi-

- sion and costs: Do walk-in clinics differ from other primary care deliver settings? Canadian Public Policy 1998;XXIV:471-84.
22. Levinson W, Roter D. The effects of two continuing medical education programs on communication skills of practicing primary physicians. *J Gen Intern Med* 1993;8:318-24.
 23. Roter DL, Hall JA, Kern DE, et al. Improving physicians' interviewing skills and reducing patients' emotional distress: A randomized clinical trial. *Arch Intern Med* 1995;155:1877-84.
 24. Kurtz S, Laidlaw T, Makoul G, et al. Medical education initiatives in communication skills. *Cancer Prevention & Control* 1999;3(1):37-45.
 25. Iverson DC, Ashbury FD. Development of a physician communication skills assessment instrument—Literature review and suggested measurement strategy. Ottawa: Health Canada, Adult Health Division, 1998.
 26. Ontario Medical Association. Physician survey on health-care reform. *Ontario Med Rev* 1999; January.
 27. O'Sullivan B, Gospodarowicz M, Ashbury FD, et al. Survey of Canadian doctors' attitudes to cancer staging. *Cancer Prev Control* 1998;2:278-86.
 28. Kruijver IPM, Kerkstra A, Francke AL, et al. Evaluation of communication training programs in nursing care: a review of the literature. *Patient Educ Counsel* 2000;39:129-45.
 29. Stein TS, Kwan J. Thriving in a busy practice: Physician-patient communication training. *Effect Clin Pract* 1999;2:63-70.
 30. Joos SK, Hickam DH, Gordon GH, et al. Effects of a physician communication intervention on patient care outcomes. *J Gen Intern Med* 1996;11:147-55.
 31. Langewitz WA, Eich P, Kiss A, et al. Improving communication skills—A randomized controlled behaviorally oriented intervention study for residents in internal medicine. *Psychosomatic Med* 1998;60:268-76.
 32. Baile WF, Kudelka AP, Beale EA, et al. Communication skills training in oncology: Description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. *Cancer* 1999;86:887-97.
 33. Roter D. The enduring and evolving nature of the patient-physician relationship. *Patient Educ Counsel* 2000;39:5-15.
 34. Marvel MK, Epstein RM, Flowers K, et al. Soliciting the patient's agenda: Have we improved? *JAMA* 1999;281:283-87.
 35. Bandura A. *Social Foundations of Thought and Action: A Social Cognition Theory*. Englewood Cliffs, NJ: Prentice-Hall, 1986.
 36. Cervone D. Thinking about self-efficacy. *Behav Modif* 2000;24(1):30-56.
 37. Kurtz S, Laidlaw T, Makoul G, et al. Medical education initiatives in communication skills. *Cancer Prevention & Control* 1999;3(1):37-45.
 38. Whitehouse CR. The teaching of communication skills in United Kingdom medical schools. *Med Educ* 1991;25(4):311-8.
 39. Tate P, Foulkes J, Neighbour R, et al. Assessing physicians' interpersonal skills via videotaped encounters: A new approach for the Royal College of General Practitioners membership examination. *J Health Comm* 1999;4:143-52.

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Table 1: Physician Confidence with Communication Strategies (Percent, n=160)

Communication Strategy	Confident: I don't really need to improve	Confident: but believe I need to improve	Not very confident: believe I need to improve	Not very confident: not a priority to improve
a. Explaining treatment options to your patient in a manner that ensures a high level of understanding by your patient	51.3	48.1	0.6	0.0
b. Helping your patient cope with her or his worries by explaining the current medical problem to her/him in a manner that facilitates coping	45.0	53.8	1.2	0.0
c. Explaining the possible benefits and risks to your patient of the recommended tests, procedures and treatment options (including medications)	40.0	52.5	7.5	0.0
d. Offering your patient specific advice about options available to resolve a common health problem	45.0	52.5	2.5	0.0
e. Conveying empathy to your patient regarding her/his problem	57.5	40.6	1.3	0.0
f. Identifying and pursuing verbal cues given by your patient	30.6	60.0	8.1	0.0
g. Identifying and pursuing non-verbal cues given by your patient	25.0	61.9	11.3	0.6
h. Communicating effectively with your patient even though you find her/him to be rather difficult	15.0	60.6	23.1	0.6
I. Actively involving your patient in the process of making treatment-related decisions	45.0	48.8	5.0	0.6
j. Expressing your concerns and preferences about possible treatment options to your patient	45.6	50.6	3.2	0.0
k. Discussing alternative or complementary therapies with your patient	18.8	44.4	31.3	5.0
l. Securing your patient's commitment to trying to follow the treatment plan that you developed with your patient	22.5	64.4	12.5	0.0
m. Using the last few minutes of the encounter to summarize the important issues discussed during the encounter	38.8	49.4	9.4	0.6

Table 2: Contribution to Patient Outcomes and Use of Communication Strategies

Communication Strategy	Strategy contributes significantly to positive patient outcomes (% yes)	20% or less	21-40%	41-60%	61-80%	81-100%
a. Addressed your patients in a polite, warm and friendly manner.	92.5	0.0	0.6	5.0	13.8	78.8
b. Used open-ended questions that encouraged your patients to discuss their problem.	86.9	3.1	6.9	19.4	32.5	33.8
c. Facilitated your patients expressing their feelings	88.8	3.8	8.1	22.5	35.6	28.1
d. Actively encouraged your patients to express their feelings about their current problem.	88.8	3.8	15.0	20.6	31.3	26.3
e. Actively expressed your understanding and empathy for your patients' problems.	91.3	1.9	8.8	16.9	39.4	30.6
f. Responded to your patients in a supportive manner when they expressed their feelings.	91.3	1.9	4.4	9.4	30.0	51.9
g. Tried to determine the psychological, emotional and social needs of your patients.	86.3	8.1	15.0	21.3	33.1	19.4
h. Tried to educate your patients about their health problems and their etiology.	92.5	3.1	6.9	11.9	34.4	41.9
I. Tried to educate and then determined if your patients had a reasonably good understanding about the possible treatment options.	87.5	4.4	8.8	16.9	41.3	26.3
j. Addressed your patients' questions at the level of detail that seemed appropriate	90.0	1.3	3.8	8.1	34.4	50.0
k. Actively involved your patients in the process of developing treatment plans.	89.4	5.6	8.8	21.3	28.1	33.1
l. Once a treatment plan was developed, you tried to get your patients' commitment to try to follow the treatment plan	85.0	5.0	11.9	19.4	27.5	32.5
m. Actively engaged your patients throughout the encounters	80.0	3.1	6.9	16.3	27.5	40.6

Table 3: Communication Strategies for Closing the Encounter, Rankings and Usage

Communication Strategies for Closing the Encounter	Rank (1-9) Mode	20% or less	21- 40%	41- 60%	61- 80%	81- 100%
a. Inform your patient that the encounter is ending.	9	41.9	7.5	7.5	9.4	7.5
b. Summarize what occurred during the encounter.	1	14.4	8.1	14.4	17.5	17.5
c. Inform your patient about what to expect as the condition gets better or worse	7	1.3	5.6	16.9	25.0	25.0
d. Ask your patient if she/he understood the nature of the problem and the components of the treatment plan.	1	2.5	8.1	14.4	20.6	27.5
e. Review the treatment plan with your patient	2	1.9	5.7	7.5	27.5	31.9
f. Encourage your patient to follow the plan and reassure her/him that it should help to resolve the problem	4	2.5	6.3	8.8	28.1	29.4
g. Clarify the next steps with your patient to ensure he/she will implement the treatment plan appropriately.	5	3.1	6.9	18.1	25.0	21.3
h. Refer your patient to support services (e.g., support programs or support groups) when appropriate	8	12.5	8.8	18.8	16.3	18.1
i. Close the encounter by expressing your concern for your patient's resolution of her/his problems	8	10.6	8.8	16.9	19.4	18.8