

Knowledge, Attitude, Practice And Barriers Of Effective Communication Skills During Medical Consultation Among General Practitioners National Guard Primary Health Care Center, Riyadh, Saudi Arabia

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Abstract

Objectives: To assess barriers, practice attitude and knowledge of primary health care physicians about communication skills during medical consultations in primary health care centers in National Guard Hospital in Riyadh, Saudi Arabia.

Design: Cross sectional study

Methodology: The study was conducted during the period from November 2009 till July 2010. Seventy primary care physicians answered a structured questionnaire about their knowledge, practice and barrier of effective communication skills during medical consultations.

Results: Survey of 70 PHC physicians showed 25(35.7%) residents, 28(40%) specialized. The majority of the physicians did receive some form of training for communication skills (85.7%), however, they did perceive lack of proper training (68.5%) as a barrier also. Common patient barriers to better communication with patients were different cultural norms from physicians or different gender (51.4%). A system related barrier noted by physicians was lack of time (82.8%). Mean score of practicing communication skills was 37.2/60 and mean knowledge score was 3.31/6 for the physicians in our study. No relationship between knowledge and practice was noted in our study but a positive correlation between age, years of experience and practicing communication skills was found (F-statistic 5.6, p value 0.006). Practice scores were significantly different for residents, staff physicians and specialists. Physicians who were confident of their communication skills and who made a conscious effort to apply the skills that they had learned were shown to score better on practicing these communication skills, Chi-sq 30.11 p value <0.001, and Chi-sq. 12.67 p value 0.002, respectively.

Conclusion: Knowledge of communication skills can improve with training however having the knowledge does not affect the practice of communication skills unless the physician is self-confident and has the right attitude of consciously applying that knowledge in his/her practice and improvement comes with age and experience.

Key words: communication skills, barrier, practice, knowledge, attitude, primary health care physicians.

Introduction

The expectations of the public from health care providers have increased over the last few decades and the majority are familiar with their rights in the health care system. As a consequence, it is of high priority that health care providers have effective communication skills. It has been well documented that the doctor-patient relationship is central to the delivery of high quality medical care. It has been shown to affect patient satisfaction, to decrease the use of pain killers, to shorten hospital stays, to improve recovery from surgery and a variety of other biological, psychological and social outcomes [1-4].

Good communication skills are integral to medical and other healthcare practice. Communication is important not only to professional-patient interaction but also within the healthcare team. The benefits of effective communication include good working relationships and increased patient satisfaction. Effective communication may increase patient understanding of treatment, improve compliance and lead to improved health outcomes. It can also make the professional-patient relationship a more equitable one. Undoubtedly however, there are barriers to effective communication ranging from personal attitudes,

to the limitations placed on doctors by the organizational structures in which they work [5].

In order to deliver effective healthcare, doctors are expected to communicate competently both orally and in writing with a range of professionals, managers, patients, families and carers. Simply recognizing the need for good communication skills is not enough; healthcare professionals must actively strive to achieve good communication skills by evaluating their own abilities. Education providers need to ensure that appropriate and effective training opportunities are available to doctors to develop and refine such skills in order to facilitate interaction with patients and others [5].

Benefits of good communication can be identified for both doctors and patients.

Benefits for patients

- The doctor-patient relationship is improved. The doctor is better able to seek the relevant information and recognize the problems of the patient by way of interaction and attentive listening. As a result, the patient's problems may be identified more accurately [6].
- Good communication helps the patient to recall information and comply with treatment instructions thereby improving patient satisfaction [7, 8]

- Good communication may improve patient health and outcomes. Better communication and dialogue by means of reiteration and repetition between the doctor and patient has a beneficial effect in terms of promoting better emotional health, resolution of symptoms and pain control [9].
- The overall quality of care may be improved by ensuring that patients' views and wishes are taken into account as a mutual process in decision making.
- Good communication is likely to reduce the incidence of clinical error [6]

Benefits for doctors

- Effective communication skills may relieve doctors of some of the pressures of dealing with the difficult situations encountered in this emotionally demanding profession. Problematic communication with patients is thought to contribute to emotional burn-out and low personal accomplishment in doctors as well as high psychological morbidity [10]. Being able to communicate competently may also enhance job satisfaction.
- Patients are less likely to complain if doctors communicate well. There is, therefore, a reduced likelihood of doctors being sued.

In all doctor-patient interactions a variety of communication skills are required for different phases of the consultation. During the start of a consultation, doctors must establish a rapport and identify the reasons for the consultation. They must go on to gather information, structure the consultation, build on the relationship and provide appropriate information [11]. There is a trend in healthcare on pushing the need for strong communication skills in medicine. In relation to communication with patients, an increasing focus on shared decision making and communication of risk, are two of the most important factors [12]. For example, communication skills can help healthcare staff to explain the results of epidemiological studies or clinical trials to individual patients in ways that can help patients to understand risk [13]. Doctors can do this more effectively if they develop relationships with their patients and if they take into account knowledge and perceptions of health risks in the general public [14].

Recent research shows that poor communication between healthcare staff and patients is still all too common. For example, when the Lothian Hospitals NHS Trust in Scotland asked patients for their views on communication issues, they found that 60 per cent of patients complained about a lack of involvement in decisions about their care, 33 per cent said they had been given no explanation of test results and 31 per cent said they had no opportunity to talk to the doctor. Twenty-three per cent complained of nurses and doctors saying different things [6].

The General Medical Council (GMC) in London stresses the need for communication skills in a number of its guidance notes [15-18]. The GMC recognizes that the communication skills required throughout a doctor's career are likely to change. Doctors should review their skills as part of their continuing professional development, and take

part in educational activities as a means of maintaining and further developing their competence [16].

Other medical professional bodies have highlighted the importance of communication skills and instituted various approaches for communication skills education.

Examples of professional endorsement of the importance of communication skills for doctors:

- Publications from medical organizations, such as the BMA's board of medical education report on communication skills and continuing professional development (1998) [19] and the Royal College of Physicians' publication Improving communication between doctors and patients (1997), [20] have highlighted the importance of communication skills.
- The General Medical Council's Professional Linguistic and Assessment Board (PLAB) examination has separated its language and communication elements with the latter being assessed through role play.
- The Academy of Medical Royal Colleges, in its recommendations for general professional training, includes communication skills among the generic skills required of all trainees.
- Royal Colleges include communication skills assessment in their training. For example, the Royal College of General Practitioners has developed formal mechanisms using video recordings for assessing communication skills in candidates [3]. The Royal College of Physicians has introduced communication skills assessment into its training.

The Royal College of Ophthalmologists includes communication skills in both the basic higher specialist training curricula and in the Part 3 MRCOphth examination.

- The London Deanery and NHS London have developed an online interactive educational program in communication skills for healthcare professionals, including postgraduate doctors undertaking the foundation years of training: www.healthcareskills.nhs.uk.

The potential of communication skills education

There is substantial evidence that communication skills can be taught, particularly using experiential methods [21].

To be effective, communication skills teaching should include [7]:

- Evidence of current deficiencies in communication, reasons for them, and the consequences for patients and doctors
- An evidence base for the skills needed to overcome these deficiencies
- A demonstration of the skills to be learnt
- An opportunity to practice the skills under controlled and safe conditions
- Constructive feedback on performance and reflection on the reasons

The problem of doctor-patient communication is more evident in Saudi Arabia for the following reasons: Firstly, the number of foreign personnel in health services is rather large [23]. This workforce communicates with

and with one another in a variety of languages different from the local one. In addition, not much orientation is given to them on local traditions and the prevalent health-related beliefs and culture. Secondly, this manpower deals with a sizeable sector of consumers, who are themselves expatriate and speak a variety of languages, and hold health related traditions and beliefs. This situation naturally creates a complex environment for doctor-patient communication. A recent study from Riyadh [24] alluded to the relationship between patient satisfaction and doctor-patient communication. As in other parts of the world, people in Saudi Arabia are expected to attempt to find out and understand all aspects of their health problems [25]. Hence the need to train and orientate physicians in the skills related to doctor-patient communication assumes greater significance. In this regard, several methods of training, especially for the situation of Saudi Arabia, can be employed [26-27].

In Saudi Arabia, the acquisition of the skill of doctor-patient communication hardly exists in any undergraduate or postgraduate medical curriculum. There is also paucity of research in this area. Consequently, it is vital that comprehensive research be done to clarify the needs of students and professionals, and outline the objectives and the modalities of training in this skill [28].

Research result of study done in KSA, to explore patient's expectations before consulting their general practitioners (GPs) and determine the factors that influence them, showed 74.6% of the patients preferred Saudi doctors, and 92.6% would like to have more laboratory tests for the diagnosis of their illnesses while more than two thirds of the patients (78.0%) felt entirely comfortable when talking with GPs about the personal aspects of their problems and about half thought that the role of GP was mainly to refer patients to specialists, while 55.2% believed that the GP cannot deal with the psychosocial aspect of organic diseases, and the commonest reason for consulting GPs was for a general check up. So, the conclusion was that the GP has to explore patients' expectations so that they can either be met or their impracticality explained. GPs should search for patients' motives and reconcile this with their own practice. The GP should be trained to play the standard role of Primary Care Physician [29].

Objectives

This study attempts to explore:

1. Current practices of communication skills of primary health care physicians in health care centers in National Guard Health Affairs in Riyadh.
2. Main barriers that can affect doctor-patient communications.
3. Primary health care physicians' knowledge about effective doctor-patient communications.

Methodology

Study Design: This is a cross-sectional study.

Setting: Held in National Guard Primary Health Care Centers in Riyadh.

Duration of Study: This study was held during the period from November 2009 till July 2010.

Sample Size: Seventy primary health care physicians participated.

Sampling Technique: Survey questionnaire was distributed to willing participants.

Sample Selection: All primary health care physicians of different levels and qualifications.

Data Collection Procedure: Data for this study were collected by questionnaire which was distributed during Sunday morning professional education activity of the department of Family Medicine and Primary Healthcare in each center for physicians and Half Day Release Course in Monday morning activity for residents.

Data Collection Instrument: Questionnaire consisted of four sections. The first section asked for physicians' demographic data, educational items and to rate their communication skills with patients. The second section asked about common barriers which can affect communication skills. The third section asked about the current practice, and the fourth asked about the physician's knowledge about communication skills by giving them a sentence and asked about what kind of skills that sentence indicates.

Ethical Consideration: Anonymity was maintained throughout. The subjects received the self-administered questionnaire with a cover letter explaining the project and the subject's rights. The choice of the items in the questionnaire was based on the level of communication skills a General Practitioner needs.

Data Analysis Procedure: Once the data collection was completed, it was checked and entered into the computer using the Statistical Package for Social Sciences (SPSS), version 15. Descriptive analysis of mean, median mode, frequencies and percentages were carried out on most of the variables, including, age, gender, self-rating of skills, years of experience, levels of experience, training history, communication skill practices and knowledge scores. In addition, relationships were explored using chi-square, linear regression, Kruskal Wallis and Mann Whitney where needed.

Results

A total of 70 primary health care physicians participated in the study. Table 1 shows, 30 (42.9%) were male and 40 (57.1%) were female. Maximum age was 58 years old and minimum age 26 years. Fifty-one (72.9%) were Saudi, 19 (27.1%) were non-Saudi. The physicians position were 25(35.7%) residents, 17(24.3%) MBBS/MD and 28(40%) specialists. The maximum years of experience were 25 years and minimum was 2 years.

Table 1: Demographic data of participants

Characteristics	Frequency	Percentage (%)	SD
Age (years)			
Mean	35.3		+/- 7.54
Median	33.5		
Mode	27		
Gender			
Male %	30	42.9	
Female %	40	57.1	
Nationality			
Saudi	51	72.9	
Non- Saudi	19	27.1	
Current position			
Resident	25	35.7	
MBBS/MD	17	24.3	
Specialized	28	40	
Experience (years)			
Mean	8.87		+/- 6.73
Median	6		
Mode	3		

Table 2 shows that 14.3% of the physicians did not receive formal training about communication skills during medical consultations, while 85.7% did receive formal training. Over two-thirds of the primary care physicians consciously applied specific communication skills frequently in their daily practice. On a self rating scale of communication skills (1-4 scale) over 75% of the physicians rated their communication skills as good or excellent.

Barriers of effective communication skills were divided into three categories: physician, patient and system barriers [Table 3 - page 11]. The two most significant physician barriers were lack of formal training (68.5%) and natural limitations e.g. quiet or shyness (41.4%). The two most significant patient barriers to communication skills reported by physicians, were cultural norms or gender different from physicians (51.4%) and personality trait of patient, i.e. too aggressive or shy (44.2%). The two most significant system barriers as perceived by physicians were lack of consultation time (82.8%) and lack of continuity of care with patients, i.e. patient seen by different doctor each time (62.8%).

Table 4 Shows that nearly 69% of physicians rarely or sometimes involved the patient in decision making; another 70% rarely or sometimes discussed goals of consultation with their patients or used 'pause or silence' in communicating with their patients. Around 2/3rds of physicians rarely or sometimes inquire about the person accompanying the patient. For female patients there were 73.2% of female physicians who rarely or sometimes felt the need to ask their female patients to remove their face-cover in daily practice to assess their facial expressions better.

In Table 5 the majority of empathy, empowerment and negotiating knowledge were answered incorrectly while the majority of listening, explaining and building rapport knowledge were answered correctly.

Characteristics	Frequency	Percentage (%)
Received formal training		
No	10	14.3
Yes	60	85.7
Consciously apply the skills		
Sometimes	26	37.1
Quite Frequently	29	41.4
Always	15	21.4
Self rating of communication skill		
OK.	17	24.3
Good	36	51.4
Excellent	17	24.3

Table 2:
Communication skills:
training and attitude

Barriers	Percentage %
Physician barriers	
* Lack of training	68.5 %
* Natural limitations e.g. quiet or shy personality	41.4 %
* Language e.g. different country /area of origin	28.5 %
* Set communication habits over years	34.2 %
* Apathy or boredom	27.1 %
Patient barriers	
* Personality trait i.e. too aggressive or shy	44.2 %
* Cultural norms or gender different from physician	51.4 %
* Expectation about physician role e.g. just give medication	42.8 %
* Educational level of patients	25.7 %
* Apathy or poor understanding towards the problem	35.7 %
System barriers	
*Lack of consultation time	82.8%
*Lack of privacy during consultation	31.4%
*Lack of support from other healthcare team	18.5%
*Lack of technology support	4.3%
*Lack of continuity of care with patients	62.8%

Table 3: Barriers to
effective communication
skills in medical
consultation

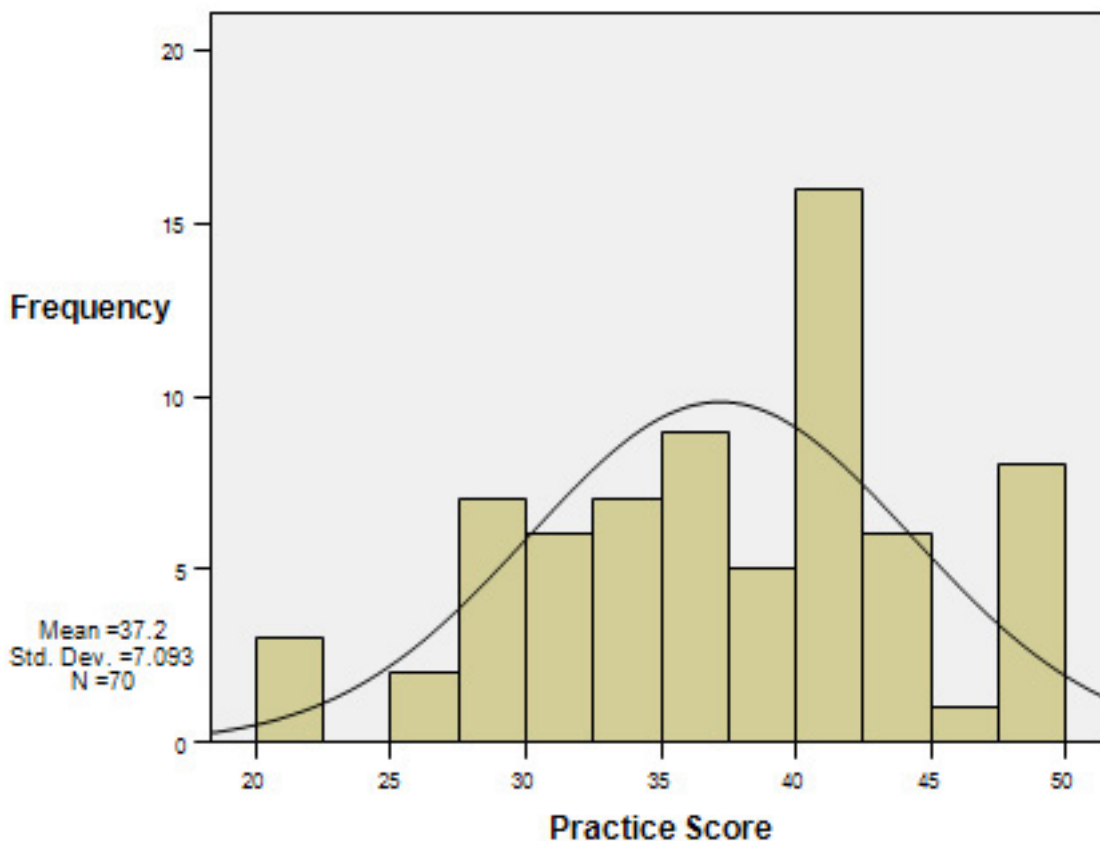
Table 4: Communication of skill practice pattern and PHC physicians

Questions	Always (%)	Mostly (%)	Sometimes (%)	Rarely (%)
1. Asks patient about understanding of medical words	2.9	34.3	57.1	5.7
2. Asks patient about the amount or type of information s/he desires	2.9	32.9	51.4	12.9
3. Patient impact in decision making	5.7	25.7	50	18.6
4. Discussing goals of consultation	2.9	27.1	52.9	17.1
5. Shows willingness to answer patient questions	20	61.4	18.6	0
6. Explains to the patient being asked question is to better understand the patient	24.3	47.1	28.6	0
7. Makes a statement that indicates recognition of patient's emotions.	10	42.9	47.1	0
8. Expresses to the patient that their experience or emotional response is appropriate.	2.9	25.7	65.7	5.7
9. Summarises the discussion at the conclusion.	5.7	35.7	44.3	14.3
10. Uses pause to communicate with patient	12.9	17.1	45.7	24.3
11. Avoid documentation when patient entered	25.7	41.4	25.7	7.1
12. Stands up to greet the patient	37.1	21.4	32.9	8.6
13. See off the patient to the clinic door or hold the door for him/her.	8.6	32.9	35.7	22.9
14. Explains to the patient what physical examination or procedure they are going to do on him or her, and for what reason.	24.3	37.1	38.6	0
15. Uses facial expressions to convey what they are thinking about what the patient is saying	8.6	45.7	28.6	17.1
16. Inquires about the person accompanying the patient.	12.9	21.4	61.4	4.3
17. (For Female Doctors) encourages female patient to remove her face-cover so that she can assess her expressions better.	14.6	12.2	53.7	19.5

Knowledge category	Correct (%)	Incorrect (%)
Empathy	47.1	52.9
Listening	62.9	37.1
Explaining	91.4	8.6
Empowerment	37.1	62.9
Rapport Building	65.7	34.3
Negotiating	27.1	72.9

Table 5: Communication skills knowledge score percentages of physicians

Figure 1: Distribution of practice scores among physicians



The total maximum score of practice questions was 60. Figure 1 shows mean of practice score 37.2, SD +/- 7.093, maximum score 49 and minimum score 20. Questions # 13 & 17 were excluded from the total score (See Table 4). For each question the value ranged from 1-4. Total score for each physician was added and all scores are presented in Figure 1.

The total score of the knowledge questions was 6. If a physician answered a question correctly one score was awarded. Thirty-one (44.3%) physicians scored 3 out of 6.

Figure 3 shows no relationship between score of knowledge and practice of communication skills based on linear regression.

Figures 4 & 5 show that age of physician and years of experience are positively correlated to practice scores. Linear regression of age and years of experience with practice scores yielded an R Square 0.143, F statistic 5.602 and P value 0.006.

Figure 2: Distribution of knowledge scores among physicians

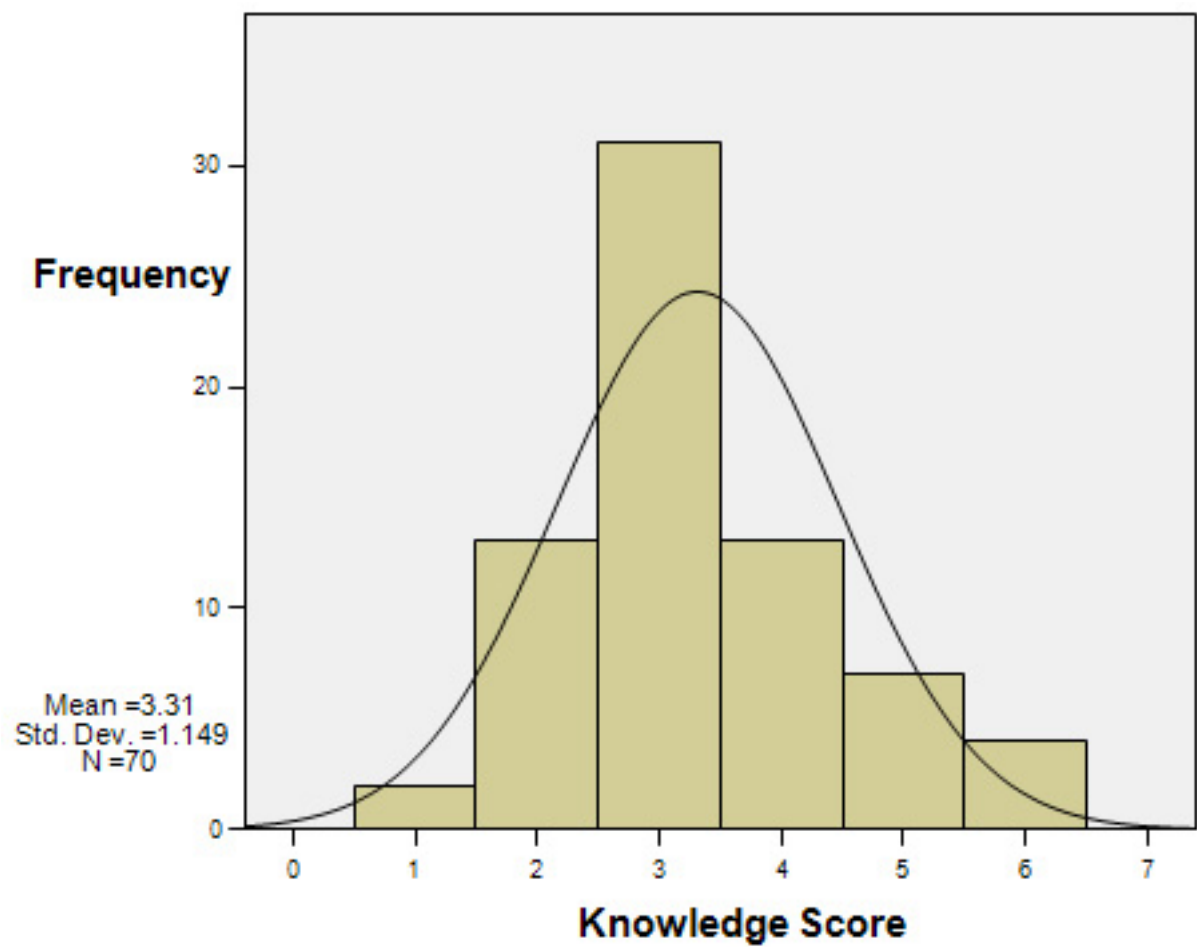


Figure 3: Relationship between knowledge and practice scores

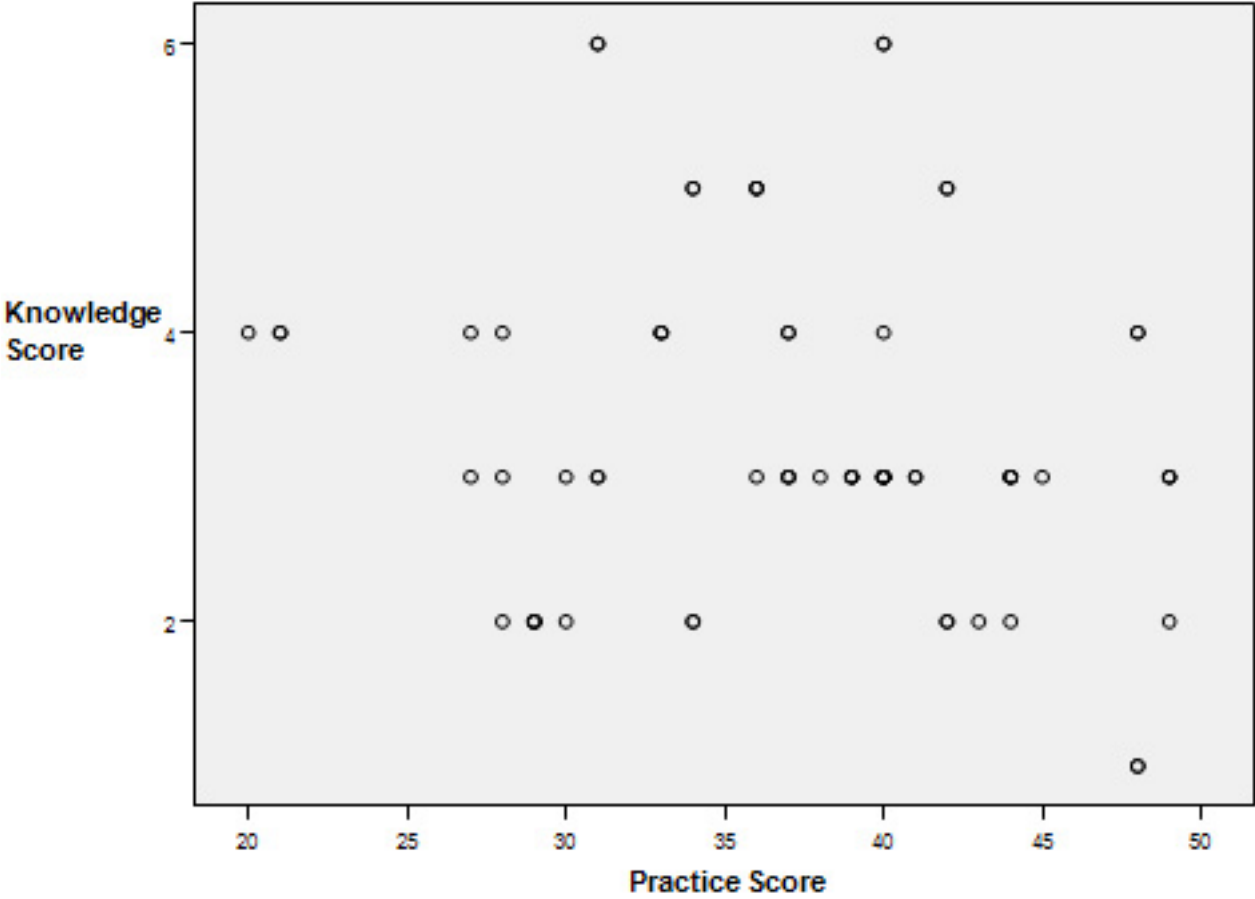


Figure 4: Relation between Age and Practice

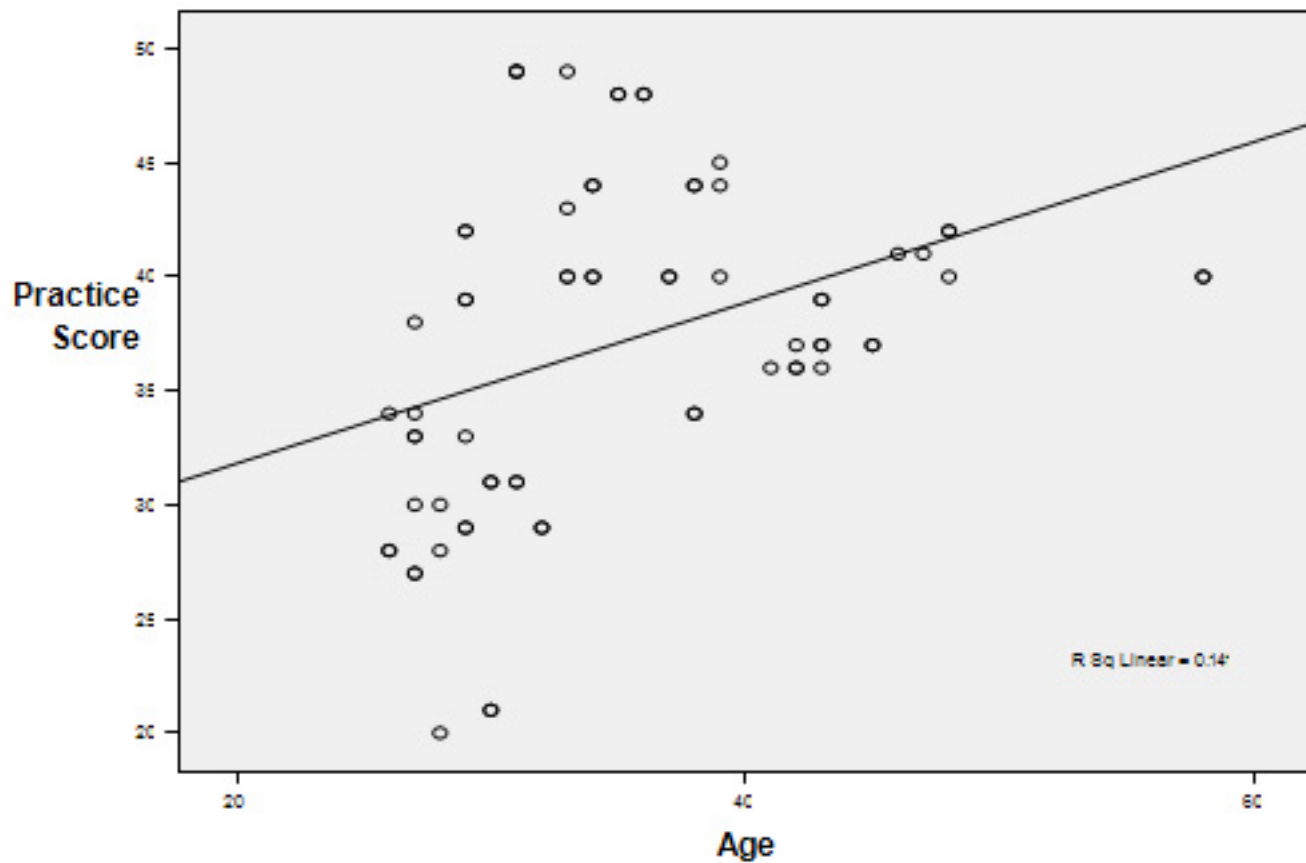


Figure 5: Relation between Years of Experience and practice

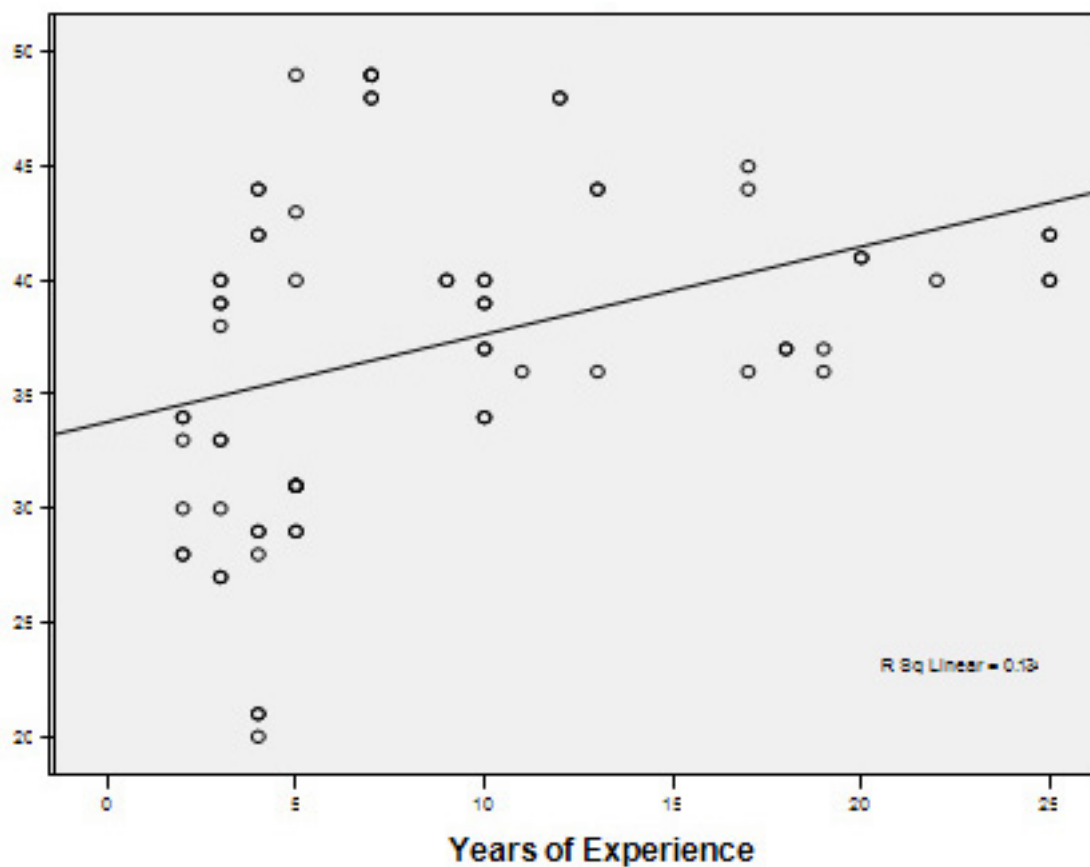


Table 6: Relationship of practice scores & communication skill values

Values	Mean Rank	P value (≤ 0.05 significant)	Test statistic
*Gender Male Female	39.22 32.71	0.185	
*Received training No Yes	40.20 34.72	0.429	
**Current position Resident MBBS \ MD Specialized	19.59 46.38 43.13	0.000	Chi – Square 24.25
**Consciously Applying the skills Sometimes Quite Frequent Always	25.27 38.31 47.8	0.002	Chi – Square 12.76
**Self Rating Scale OK. Good Excellent	14.21 37.88 51.76	0.000	Chi – Square 30.117

*Mann – Whitney Test

**Kruskal – Wallis Test

The score of practicing communication skills was found to be not significantly different based on gender of physicians. Using Kruskal-Wallis Test it showed that communication skills practice scores were significantly different between resident, MBBS/MD and specialists [Table 6].

Table 7: Relationship of knowledge scores & specific variables

Variables	Mean Rank	P value (≤ 0.05 significant)	Test statistic
*Received training No Yes	18.50 38.33	0.003	
**Current position Resident MBBS \ MD Specialized	33.92 29.35 40.64	0.144	Chi – Square 3.881
**Self Rating Scale OK. Good Excellent	35.47 38.44 29.29	0.273	Chi – Square 2.596

*Mann – Whitney Test

**Kruskal – Wallis Test

The score of knowledge of communication skills was significantly different based on whether the physicians received training or not [Table 7], however there was no statistically significant difference between the knowledge scores on the basis of current position, self-confidence of practicing skills or application of communication skills consciously.

Multiple comparisons was done using Post Hoc Tukey test between practice scores and current position of participants. It showed there is a real difference between communication skills practice score of residents with that of MBBS/MD or specialized physicians but there was no difference between MBBS/MD practice score and specialized physicians.

Applying communication skills consciously was influenced by the current position of physicians; most residents in a sample (25) applied their communication skills rarely or infrequently whereas 23 of the 28 specialized physicians applied their skills quite frequently, Chi-square 15.505 and P value 0.004.

The residents were less confident of their communication skills, while MBBS/MD physicians and specialized physicians rated their communication skills as good and excellent, chi-square 13.754 and P value 0.008.

Discussion

This study provides information not previously available from National Guard primary health care physicians on the knowledge, attitude, practice and barriers of effective communication skills during medical consultation. The distribution of population was almost equal between male (42.9%) and female (57.1%), the majority of them were Saudis (72.9%), between residents (35.7%), specialized (40%) and staff physicians (24.3%). Average years of experience in primary care ranged between 2-25 years. Most of the physicians did receive formal training of communication skills in our study (Table 2). Communication skills training has been embedded in the curriculum of graduate medical and post-graduate trainings for over 15 years in some parts of the world [5]. Over forty percent of physicians applied communication skills frequently and 51.4% rated themselves as good communicators (Table 2).

Most of the physicians thought that lack of training (68.5%), cultural norms or gender difference between patient and doctors (51.4%), and lack of time (82.8%) are the main barriers to apply effective communication skills with patients. In our study, one of the main patient related barriers, as perceived by the physicians, was different cultural norms or gender from that of the physician. There is one study that showed the majority of patient's preferred Saudi doctors, suggesting that doctor-patient communication is much easier when both patient and doctor come from the same culture [29].

In the same study most patients expected GPs to spend some time explaining the nature of their illnesses and the results of tests done [29]. This is consistent with the findings of other studies [30] and this study, as most physicians answered correctly the knowledge question about explaining to the patient in detail, as an important communication skill (Table 5).

A study conducted to assess the impact of two communication skills training programs on the evolution of patients' anxiety following a medical consultation found no significant difference was observed. Results of that study confirm results of other studies that have shown that some reassurance may produce anxiety and have suggested that communication skills are probably efficient if physicians discuss their patients' concerns in depth by using some basic communication screening questions [31].

In this study using non-verbal cues to communicate with patients were obviously rarely and sometimes used (Table 4). In other studies they found that patients offer clues that present opportunities for physicians to express empathy and understand patients' lives. In both primary care and surgery, physicians tend to bypass these clues, missing potential opportunities to strengthen the patient-physician relationship. Research on teaching communication skills demonstrates that physicians can learn to modify their communication style [32-34].

Despite widespread interest in the effects of physician gender on the care process, the literature describing these effects is small [35], and in this study there were no differences between male and female physicians in practicing communication skills.

It was observed in this study that there was no correlation between knowledge and practice of communication skills (Figure 3) suggesting a gap between knowledge and practice. It was also noted that the physicians who consciously applied the communication skills in their practice, scored better in daily practice of these skills with their patients. The physician may have knowledge but if he did not make a deliberate effort to apply that knowledge in his practice, it did not show in his actual practice.

Most residents received training of communication skills during their program but they seemed to apply these skills in their daily practice to a lesser degree than the MBBS/MD and specialized physicians (Table 6). Communication skill training is very important to have knowledge of skills but having a good knowledge did not affect the practice if the physician did not have the attitude of applying that knowledge in the practice (Table 7).

Specialized and MBBS/MD physicians were more confident in their self rating of communication skills, while the majority of residents evaluated their communication skills with lesser self-confidence. This translated into better practice scores.

Figure 4 and 5 show there is a strong relation between age and years of experience in the medical field with practicing of communication skills. Years of practice was found to be a larger predictor of practicing communication skills when compared to age, however both factors had significant overlap, suggesting that with increasing age and experience in work, physicians practiced their communication skills more.

A study showed that the level of communication skills and the content of the consultation with regard to psychosocial issues, patient concerns and the informing and planning of procedures (with a representative patient in a general practice setting) among graduate medical students are significantly correlated; that means having the knowledge of communication skills is important [36], however in this study, age and years of experience were more important than having good knowledge only.

It means that training is important but having self confidence and a genuine desire to apply that knowledge are valuable in practicing communication skills, which certainly improves with age and experience.

Limitations

There are four limitations of this study which deserve emphasis:

1. Small sample size.
2. Study was done among primary health care physicians in National Guard which cannot be generalized to PHC physicians in Saudi Arabia.
3. The majority of the sample was Saudi and 35.7% were residents.
4. Only six categories evaluated the knowledge of physicians.

Conclusion

This study suggests that knowledge base in communication skills can improve with training however having the knowledge of good communication with patients does not influence the practice of communication skills unless the physician is self-confident and has the right attitude of consciously applying that knowledge in his/her practice. Lastly, communication skills improve with age and experience.

Recommendations

1. Younger physicians need to put more emphasis on the use of communication skills; having the knowledge is not sufficient.
2. Involve the less expert physician in a teaching clinic or increase the number of simulated clinics during the training of communication skills program and improving the continuity of care between physicians and their patients will show good outcomes in improving the application of those skills.

3. How can doctors best continue to develop their skills, apply them within their daily work, survive emotionally, and feel more satisfied? How can persistent behavioral, perceptual, and personal changes be produced? Self learning and self monitored feedback, distance learning, and serial workshops seem to be promising approaches for qualified doctors.

4. Finally, it is my hope that the findings will help in planning a strategy for improving services, making effective communication skills attitude more acceptable and believable in the PHC sitting in our community to improve patient care in all aspects.

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