

Communication skills of specialist doctors: Assessment with SKAF scale a new tool

Khalid Umar Gill¹, Faisal Nazeer Hussain²,
Amina Husnain³, Sardar Sohail Ali Khan⁴

ABSTRACT

Objective: To evaluate the standards and uses of communication skills of specialist doctors during the doctor-patient interactions among a sample of specialists belonging to various specialities and based at different hospitals of Lahore.

Methodology: One hundred specialists were asked to participate in the prospective, questionnaire based survey in Lahore. These volunteers were asked to fill a form keeping in view their current practices. The scores thus achieved were measured using a proposed SKAF score. The results were graded into four parts depending upon the score achieved by the subjects.

Results: Twelve people never returned the survey instrument. Of those who did majority scored as good or excellent. Females showed a better score than males. Those who had previously been instructed formally did better on the SKAF scale.

Conclusions: The need of formal hands on training workshops on Communication Skills in both under graduate as well as post graduate trainees cannot be reiterated.

KEY WORDS: Communication skills, Survey, Clinicians.

Pak J Med Sci October - December 2010 Vol. 26 No. 4 753-758

How to cite this article:

Gill KU, Hussain FN, Husnain A, Khan SSA. Communication skills of specialist doctors: Assessment with SKAF scale a new tool. Pak J Med Sci 2010;26(4):753-758

INTRODUCTION

Good communication skills are essential for high quality, effective and safe medical practice. These skills are used for information gathering, diagnosis, treatment and patient's education. Recent research shows that when the doctor uses effective communication skills, both doctor and patient benefit. About two decades ago 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's management".¹ Available data indicates the quality of doctor-patient communication has a significant impact on patient's satisfaction, medical outcome and medical costs.²⁻⁴ Patient satisfaction appears to be enhanced when the patient and the physician have a similar orientation regarding their respective roles during an interaction.⁵ Many studies have pointed out that clinicians interrupt the patient during their talk far more frequently than expected. Studies have revealed that patients identify new problems in over 20% of the closing

1. Khalid Umar Gill,
Associate Professor Psychiatry,
2. Faisal Nazeer Hussain,
Associate Professor of Orthopaedic Surgery,
3. Amina Husnain,
Assistant Professor, Medical Unit II,
Allama Iqbal Medical College,
Lahore.
4. Sardar Sohail Ali Khan.
Professor of Surgery,
1,2,4: Avicenna Medical College,
Lahore, Pakistan.

Correspondence:

Khalid Umar Gill,
Associate Professor Psychiatry,
Avicenna Medical College,
DHA Phase IX,
Bedian Road, Lahore,
Pakistan.
E-mail: khalidgill786@hotmail.com

- * Received for Publication: June 12, 2010
- * Revision Received: July 23, 2010
- * Revision Accepted: July 26, 2010

moments of their consultation with the doctor and these interruptions have a negative bearing on patient's satisfaction with the consultation. These well-documented problems that occur with doctor-patient communication are still a concern.^{6,7} Levinson and Chaumenton 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 surgeon talking more than the patients.

A lack of focus on the patient's agenda is demonstrated in a study involving family physicians in which patient's attempts to express their concerns were completed in only 28% of consultations, with the physician interrupting the patient with an average of 23 seconds from the start of the conversation.⁸ Finally if there is poor communication and sub-standard interaction between the patient and his family physician the patient is more likely to use emergency department rather than the usual family physician. Though there are many recommendations and consensus documents about what a physician should do in order to achieve mastery in communication skills but there is no measurable popularly accepted method to gauge the success of such an effort. In the light of various sources available as guiding principles a proposed scale SKAF (Sohail-Khalid-Amina-Faisal) was devised in a bid to measure the communication skills of physicians. This study was aimed to find out some of the deficient areas and a questionnaire based survey was done including one hundred specialist doctors of Lahore, Pakistan.

METHODOLOGY

A) Preparation of the Instrument (Questionnaire):

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 the methods used to assess these skills¹⁰ as given in Table-II. Attributes of a good office patient interview by the clinician were identified along with identification of signs that point to poorer doctor patient communication.

The second step involved phrasing and preparing appropriate questions i.e. the number and language of the questions which should cover as many as possible the different factors which either enhance or obstruct an effective communication between the doctor and patient during consultation. Eventually a questionnaire consisting of 20 questions was finalised (the questionnaire is available on request).

The questionnaire was developed for the clinicians to fill in the backdrop of their current practices. They were asked to mask their identity and return their forms sealed in an envelop in order to control the possibility of bias that could make the participant hesitant obstructing him from giving his true opinion.

The third step involved having the instrument reviewed by a panel of experts, to run a small scale trial and review the deficiencies in the phrasing of various questions. A scoring methodology was also devised in order to isolate various grades of skills expressed by the participants.

Table-I: Essentials of communication skills-Kalamazoo consensus statement.⁹

Open the discussion.

- * Allow the patient to complete his/her opening statement.
- * Elicit the patient's full set of concerns.
- * Establish/maintain a personal connection.

Gather the information.

- * Use open-ended and closed-ended questions appropriately.
- * Structure, clarify and summarise information.
- * Actively listen using verbal and non-verbal techniques.

Understand the patient's perspective.

- * Explore contextual factors (e.g. family, culture, spirituality.).
- * Explore beliefs, concerns, expectations about health and illness.
- * Acknowledge and respond to the patient's ideas, feeling and values.

Share information.

- * Use language the patient can understand.
- * Check for understanding.
- * Encourage questions.

Reach Agreement on problems and plans.

- * Encourage the patient to participate in decisions to the extent that he/she desires.
- * Check the patient's willingness and ability to follow the plan.
- * Identify and enlist resources and supports.

Provide Closure.

- * Ask whether the patient has other issues or concerns.
 - * Summarise and affirm agreement with the plan of action.
 - * Discuss follow-up.
-

Table-II: General Factors Known to Enhance or Obstruct Effective Communication.

<i>Behaviours Which Enhance Effective Communication While Seeing Patients:</i>	<i>Behaviours Which Obstruct Effective Communication While Seeing Patients:</i>
* Empathy	* Lack of privacy and exclusivity
* Friendliness	* An awkward and un-comfortable seating
* Courtesy	* Repeated interruptions
* Explanations	* Not being attentive to the non-verbal cues
* Psychosocial conversation	* An Anxious and preoccupied doctor
* Good eye to eye contact	* To eat/drink or attending phone calls
* Relax while listening	* Behaving as tired and yawning
* Forward lean and head nodding	* Selective listening
* Give notice to non-verbal cues	To look down patient and behaving as a superior
* Use of minimal prompts.	
* Direct body orientation	
* Listen and respond to feelings	
* A genuine reassurance and support	
* Clarification and summarisation	

B) Selection of a Sample: The participants were one hundred specialist physicians who were working in various capacities in government or private sector. They were included through convenience sampling and asked to fill the survey form voluntarily. For other characteristics of the participating clinicians see Table III & IV.

C) SKAF Scale: The proposed scale was named SKAF (Sohail-Khalid-Amina-Faisal). It is a survey form consisting of basic information about the profession of the participant. The questionnaire consisted of 20 questions and the participants were asked to opt for one of the five options as reply; always/often/sometimes/rarely/never (Table-III). Most questions had been phrased positively so that always would mean a score of four and never meant a zero. Some questions pointed to negative attributes and were scored in the reversed order meaning a zero for an always response. The maximum score attainable by a physician in KAFS scale was 80 and the minimum possible was zero. The band in between was divided into four equal parts 0-19(poor), 20-39(fair), 40-59(good) and 60-80(excellent). The results of small scale trial run of the survey were plotted against the scale to see the applicability of the study.

Table-III: SKAF Scale and the Score of the cohort.

<i>SKAF Scale</i>	<i>Scores</i>	<i>No.</i>	<i>%</i>
Excellent	60-80	47	53.41
Good	40-59	40	45.54
Average	20-39	1	1.14
Poor	0-19	0	0.00
Aggregate	60.53	88	100

RESULTS

The response rate was 88%. Twelve questionnaires were never returned by the participants without giving a reason. The average age of our cohort was 47.04 yrs (range30-70). Out of the 88 questionnaires returned the participants missed to fill 36/2288 blank spaces (0.64%). Twenty two were females (25%) and 62 were males (70.45%) while four (4.54%) did not mention about their gender. Thirty eight (43.18%) were involved in Government job, 37 (42%) were in

Table-IV: Demographic and professional characteristics of the cohort.

<i>Characteristic</i>	<i>Inclusion Criterion</i>	<i>Findings</i>
Age	No discrimination	47.10 yrs (30-70)
Gender	No discrimination	22F 62M
Nature of job	No discrimination	Government 38(40.1%) Private 41(46.6%) Self employed 1(1.1%)
Specialty(except those from Radiology/ Anaesthesia)	Surgery & Allied Medicine & Allied	43 (54.74%) 38 (62.82%)
Attended a workshop on Communication Skills	No discrimination	
Self assessment of participants	Yes No	22 63
	No response	3.41%
	Excellent	10.22%
	Very good	40.91%
	Good	35.23%
	Fair	9.09%
	Poor	1.14%

Table-V: Self assessment vs attending a workshop.

<i>Self Assessment</i>	<i>No Response</i>	<i>Did not attend a workshop</i>	<i>Attended a workshop</i>	<i>Total</i>	<i>%</i>
No Response	2	0	1	3	3.41
Excellent	0	4	5	9	10.22
Very good	1	8	27	36	40.91
Good	0	8	23	31	35.23
Satisfactory	0	2	6	8	9.09
Poor	0	0	1	1	1.14
Total	3	22	63	88	100

private job, four (4.55%) were self employed and nine (10.22%) did not respond to this question. Forty (45.45%) belonged to Medical and Allied specialties and 48(54.54%) were from Surgical and allied specialties. Sixty three (71.60%) had attended a formal workshop for communication skills while 22 (25%) had not while 5 (5.68%) did not respond to this question. Regarding the self assessment of the participants 9 (10.22%) claimed their skill being excellent and 36 (40.91%) said they were very good (Table-V).

When the responses to the questionnaire was plotted against SKAF Scale 47 (53.41%) participants scored excellent, 40 (45.45%) good and one (1.14%) participant scaled as fair. None fell into poor category. The average aggregate score was (60.53 range 39-76) as given in Table-V.

DISCUSSION

Every doctor develops his own way of communicating with his patients. His practices are affected by his environments, social norms, training background, specialty, work load and attitude: both his own and the patients. In general practice the well accepted patient-centred method holds good for all practical purposes.¹¹ The data collected at the end of the study revealed that out of a 100 survey form

Table-VI: Performance against SKAF Scale among those who have attended a workshop on Communication skills.

<i>SKAF Scale</i>	<i>Never attended a Workshop</i>		<i>Attended a Workshop</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
Fair	1	4.55	0	0
Good	12	54.54	26	41.26
Excellent	9	40.91	37	58.73
Total 88	22	25	63	71.52
Did not Respond			3	3.41

distributed to specialist doctors 12 were not returned and from among the ones returned some responses were missing i.e. 36/2288 (0.64%) responses.

Some of our participants (4/88, 4.54%) missed to reveal their gender. The ability to read a piece of information and respond to it also forms a vital part of communication skills. It points to the attention a reader gives to the information being rendered to him by the patient. It may not be a good indicator but does point to the way we as specialists processes the information that we get. The self assessment of the participants was not accurate in predicting efficacy of their earlier training nor would it be an easy task to correlate it to the score they attained on SKAF Scale. One can object rightly that the efforts to measure attitudes are very difficult to quantify. Communication skills are a reflection of a physicians attitude as well apart from the noncholastic development of his personality during formative training period. A look at the Table V & VII will show that SKAF Score is much higher than the self assessment of the doctors. Communicating is the result of many abstract mental processes and is very difficult to measure scientifically. SKAF score being presented here is a pioneer effort in this regard which may not stand the test of time but it would not be an over statement that it may prove to be a beginning.

Female physicians have been known to take on an average, two-minutes longer for consultations.¹² In this time they are reported to engage in more active partnership behaviours, positive talk, psychosocial counselling, psycho social question-asking and

Table-VII: KASF Scores in both genders.

<i>SKAF Score</i>	<i>Males</i>	<i>62</i>	<i>Females</i>	<i>22</i>
Excellent	29	46.77%	16	72.73%
Good	32	51.61%	6	27.27%
Fair	1	1.61%	0	0.00
Poor	0	0.00	0	0.00

emotionally-focussed talk.¹² Among our participants twenty two were females (25%) and 62 were males (70.45%) while four (4.54%) did not mention about their gender. The males scored proportionately on a lower side than the females-Table-VII. This could be due to well known better command of the females over the lingual communications. It also reflects upon an incidental finding pointing to a male predominant (70.45%) specialist community.

Most of the training programs in the past aiming to produce specialist did not focus much upon formal teaching of communication skills to the doctors. Major part of the affective learning domain was exchanged informally between the trainer and the trainee through ages old tradition of apprenticeship.¹² Among our participants sixty three (71.60%) had attended a formal workshop for communication skills while 22 (25%) had not while five (5.68%) did not respond to this question. Although our results show that most of our specialist clinicians show adequate score at SKAF score i.e. 41.26% good and 54.73% as excellent yet when a confounding variable of having attended a formal workshop is added the lower scores by those who have not attended the results emphasise the need of formal training in this much neglected skill. Problems no longer lie in demonstrating the effectiveness of therapeutic communication skills rather today's problems are concerned mainly with how to transfer such skills from training programs into daily practice. Our post graduate training programs did not stress need for structured teaching activity in this field in the past except for a recent trend set by one institute yet the SKAF score averages at 60.53 (range 39-76). Communication skills cannot be considered in isolation rather these are a part of the process of the consultation in the clinic or inpatients. The concern raised by our results does direct us to presume that formal training in hands on setting of a workshop does have its positive results.

Communicating skills need to be learnt formally in order to control blocking behaviour often displayed by physicians. The trainee doctor must be encouraged to practice and to receive feedback about his own performance.¹³ Once habits are formed and attitudes have become fixed training of the trained renders a risk of distressing and deskillling the doctor. These skills should be taught formally during formative periods allowing practicing with simulated patients or actors if needed. The mock practice has the advantage that the nature and complexity of the

task can be controlled by the trainer. "Time out" can be called when the interviewer gets stuck. A look at the Table-VI shows clearly that those who have been given formal training on communication skills have excellent score as compared to the group who had not been where most tend to fall in the lower group. The opportunity to master these skills comprehensively may not be available to the trainee in the busy residents work schedule in the ward. In a dedicated interactive teaching session of a workshop the trainees get ample chance to improve their skill those related to patient especially listening. When the trainer allows the group of trainees to interact the group can then suggest how the interviewer might proceed best. This helps to minimize deskilling. In contrast, asking the doctor to perform a complete interview may cause the doctor to lose confidence because "errors" are frequently repeated and pointed out by the trainer. Each question was phrased in order to find out how important does the clinicians think each good attribute is e.g. an anxious and preoccupied doctor will not be able to win the confidence and the participants were asked "Do you feel yourself preoccupied or anxious during the consultation?". The average score achieved for this particular question is 3.17/4. This survey was done prospectively asking specialists to give their general response to the question asked. Their own judgement can be biased particularly when they are going to judge their own behaviour. This limitation of the study cannot be ignored until a feed back from the patient of the same doctors is collected simultaneously to compare the self perception of the doctor and his scores. The questionnaire substitutes for these shortcomings by phrasing of each question so that the response tendered by the participant should reflect upon his aptitude towards one of the attributes of a good interview in the clinic, SKAF score has been devised as a surrogate of objectivity.

CONCLUSION

The communications skills being displayed by our specialist corpse may look adequate on the surface yet the factual need of a formal hands on training program with mock situations or actors should be included in various curricula at all stages of both under and post graduate teachings. The written communication skills should also be included in such a program.

Acknowledgements and declarations of conflict of interest: This study has been conducted by all the four workers with their own sources without any

financial or physical funding from any organisation or a grant. The authors have no conflict of interest to declare. We are indebted to the participants of the survey who did not hesitate in giving us their true opinion while filling the survey.

REFERENCES

1. Simpson M, Buckman R, Stewart M. Doctor-patient communication: The Toronto consensus statement. *BMJ* 1991;303:1385-1387.
2. Wiggers JH, Donovan KO, Redman S. Cancer patient satisfaction with care. *Cancer* 1990;66:610-616.
3. Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: Effects on patient outcomes. *Ann Intern Med* 1985;102:520-528.
4. Stewart MA. Effective physician-patient communication and health outcomes; A review. *Can Med Association J* 1995;152:1423-1433.
5. Krupat E, Rosenkranz SL, Yeager CM. The practice orientations of physicians and Patients; the effects of Doctor-Patient congruence on satisfaction. *Patient Education Counsel* 2000;39:49-59.
6. Beckman HB, Frankel RM. The effect of physician behaviour on the collection of data. *Ann Intern Med* 1984;101:692-626.
7. Richards T. Chasms in communication. *BMJ* 1990;301:1407-1418.
8. Marvel MK, Epstein RM, Flowers K. Soliciting the patient's agenda: Have we improved? *JAMA* 1999;281:283-287.
9. Brunett PH, Cambell TL, Kelly KC, Danoff D. Essential elements of Communication in medical encounters: The Kalamazoo Consensus Statement, *Acad Med* 2001;76:390-393.
10. 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.
11. Hawken SJ: Good communication skills: Benefits for doctors and patients. *New-Zealand Family Physicians* 2005;32(3):185-89.
12. Singh T, Gupta P, Singh D. *Principles of Medical Education*; Jaypee Brothers, New Delhi 2009.
13. Desai C, Anshu, Singh T, Sood R. Summary of online discussion on non-scholastic abilities: Personnel communication-through internet; July 2007 by the FAIMER 2007.