

# Exploring the barriers to effective communication between senior doctors and patients

Developing the dance of a medical consultation

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# Background

- Doctors are regularly criticised for not communicating well
- 75% of all complaints recorded by the NHS involve an element of failure of communication
- Things do not seem to have changed despite extensive communication skills training being offered to all grades of doctors

# My context



- Consultant in Palliative Medicine
- Trust employed consultant but also Medical Director of an independent Hospice
- General Practice trained

# Companions on the Journey



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*“To the typical physician my illness is a routine incident in his rounds while for me it is a crisis of my life. I would feel better if I had a doctor who at least perceived this incongruity.....I just wish he would.....give me his whole mind just once, be bonded with me in one brief space, survey my soul as well as my flesh, to get at my illness, for each man is ill in his own way”  
(Broyard 1993).*

# Hidden issues around communication



- Medical information is often complex and ambiguous
- Medical information has emotional, social and political elements
- There may be considerable uncertainty around possible outcomes
- There are perceived time constraints generated by organisational issues

# Methodology

Grounded in the messy world of everyday clinical practice

Honest attempt to understand the complexity and ambiguity of communication

Based on critical realism  
– Intuition and Problem solving

# Learning equation

$$L = f(P + Q)$$

L – learning

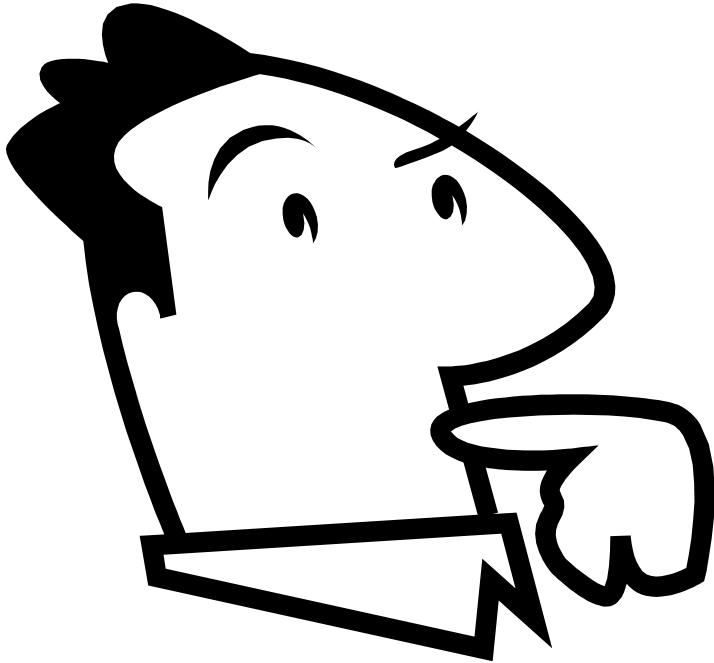
P – Programmed learning

Q – Questioning insight

*F* – function of a spiral



# Action Research



Revans' Beta system

Survey

Hypothesis

Action

Inspection

Incorporation

Free to change- not bound by rigid concepts of what we have been, must be or should be

Openly show a balance of self-interest & a sympathetic concern for others

No façade to hide behind – not feared by others

Cognitive valency: set shares ideas, concepts, perceptions, knowledge & learning

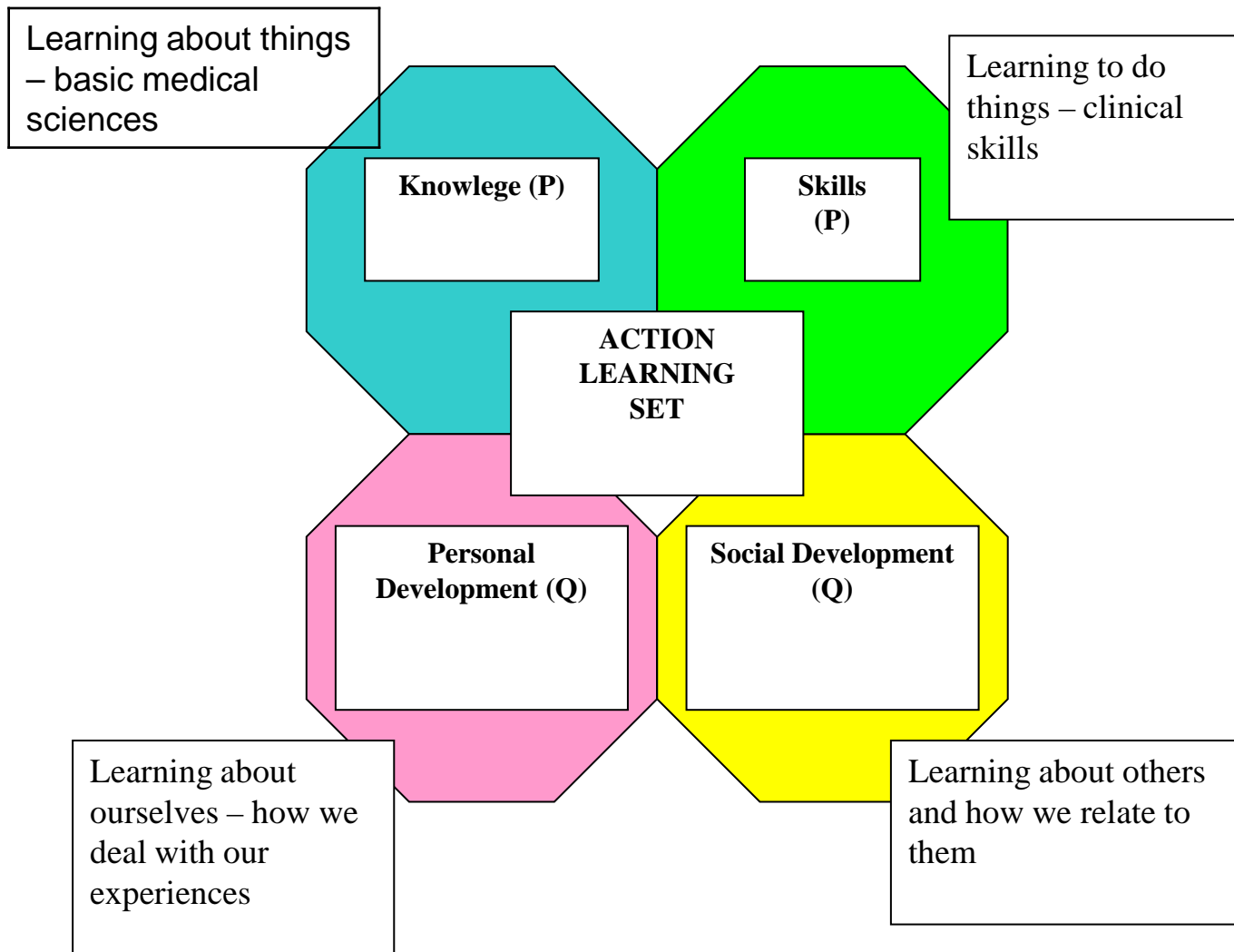
Free to use our creative imagination for problem solving rather than defending ourselves

Individual comfort – nothing to hide

Able to focus on the problem rather than proving morality or consistency

*Key attributes of an action Learning Set  
After Botham*

# Action Learning (after Pedler)



# Methodology

## COMBINING

Action learning

$$L = f(P + Q)$$



Action Research

System Beta

Action/reflection cycle

## AND

Systems thinking

Communication as a purposeful activity based on an explicit world-view rather than a theoretical model

Communication as an open, dynamic, purposeful human based system based on number of subsystems

# What did I do?



- What is already known
  - Literature review
  - Communication skills facilitator
  - Clinical experience
- 5 Consultant study days around communication issues
- Survey of patients and consultants views
- Questioning insight from Action Learning Set
- Questioning insight from a personal reflective diary

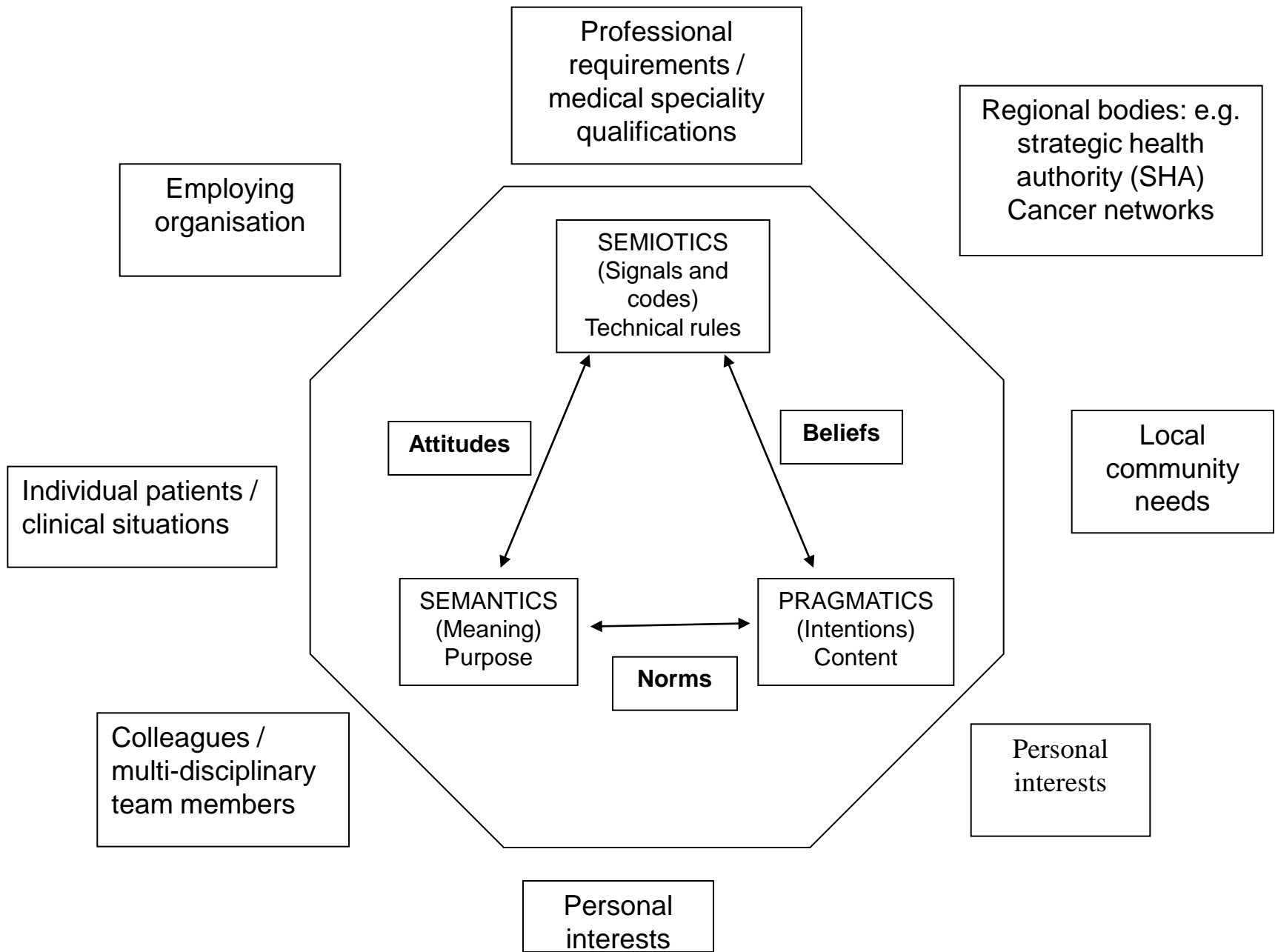
# Synthesis rather than analysis

## Distillation of:

- My understanding of the literature
- The feedback from study days
- The feedback from the survey of out-patients
- The influence of the set
- My recall and interpretation of events

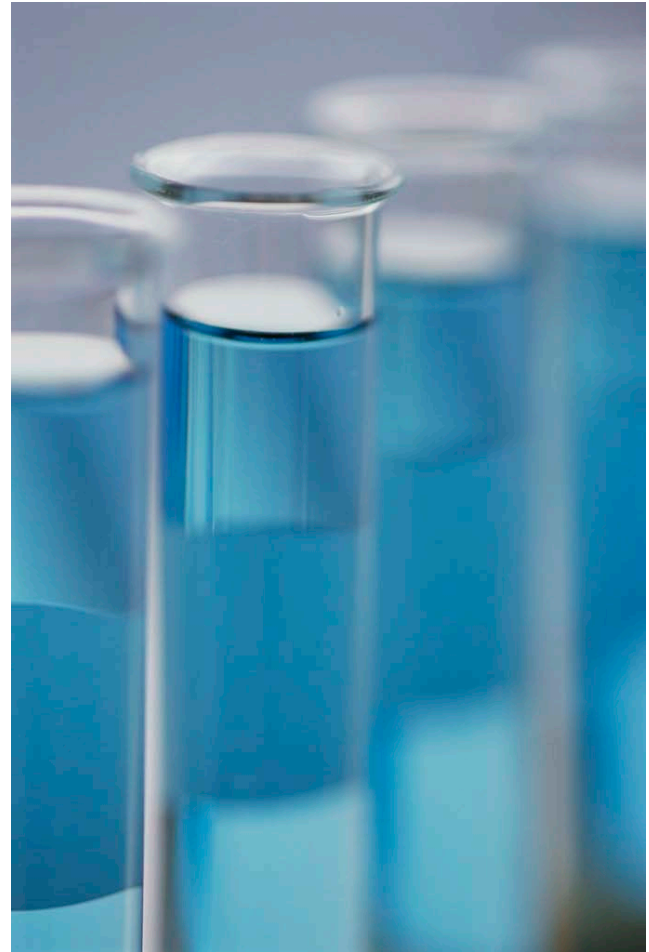
## Seeking

- Coherence and correspondence



# Contribution to Research

- Novel use of soft systems thinking
- Quantitative research methodology in the context of medicine
- Opens up new lines of enquiry





# Soft System Thinking

Root definition of the purpose of a system

- C – customers (beneficiaries or victims)
- A – actors (who drive the system)
- T – transformational process
- W – weltanschauung (prevailing culture)
- O - owners
- E – environmental constraints

Checkland

# Proposed Root Definition of a Consultation

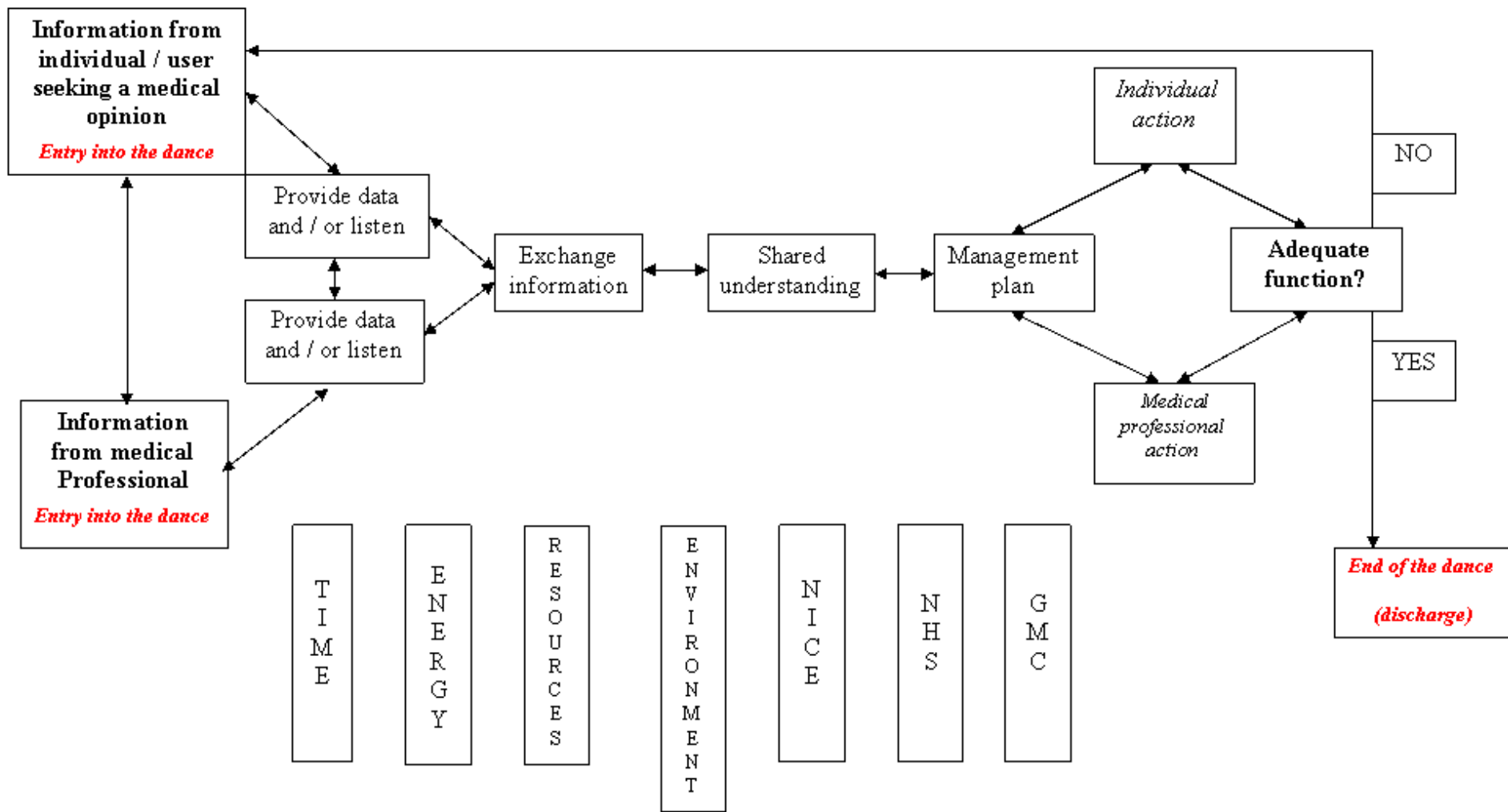
*“A system where an individual (user) seeks a professional medical opinion that enables the development of a mutual understanding of the problem presented such that, with the appropriate use of available resources, a mutually accepted plan of action is developed. Where possible such a plan should allow an individual to function as well as they can, given the restraints of their problem and its impact on their physical and mental capacity.”*

# Contribution to Theory

- The **model of communication** based on a logical use of information and the passive reception of that information is no longer sufficient
- Proposes a **social model** of communication as a dance where participants have equal roles in the transmission of information
- Contributes to the evolving understanding objectivity and management of uncertainty.



Figure 6.2: Proposed soft system model of the communication process in an out-patient medical consultation



Where: NICE – National Institute for Clinical Excellence  
 NHS – National Health Service  
 GMC – General Medical Council

# Limitations

- Subjective and emotive
- Situation specific
- Speciality specific possibly
- Generalisations rather specifics
- No attempt to identify causality
- Unproven use of the methodologies

# Achievements

New understanding of the process of communication as

- Social
- Inherently ambiguous
- As a partnership between the participants
- Strongly influenced by organisational structures and systems
- A dance of infinite texture and variety but with an identifiable structure



*A doctor who recognises the patient in the face of the sickness, who respects the patient's strength despite the fear, who accompanies the patient through the territory of illness that the doctor knows well, and who honours the meaning of the patient's suffering provides not just knowledge of diseases but knowledge of the direction toward either health or the ability to live authentically without health. Such a doctor provides company to combat the isolation and with it an animating belief in the patient's ability to endure whatever will come.*

*(Charon 2006).*



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