Improved communication between doctors and with managers would benefit professional integrity and reduce the occupational medicine workload

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Background
Professional expectations for communication skills are explicit. These skills are needed for professional integrity and personal morale. Nevertheless, occupational physicians see doctors as patients for whom communication among between doctors and with their managers are the principal cause of their presenting health problems.

Aim
To describe the frameworks of professionalism in medicine and the duty to care for good communication; present issues surrounding competency in communication skills; identify health problems among doctors associated with poor communication; and consider roles of economic appraisal and preventive strategies.

Method
A literature review identified key publications of professional expectations and requirements of doctors for their communication skills. Health problems among doctors associated with poor communication and presenting at least twice in a National Health Service (NHS) occupational health (OH) department during January–December 2002, were sought by manual retrieval of all doctor–patient records. The categories of communication difficulty were agreed in the focus group discussion of the presenting problems with occupational physicians.

Results
Nine categories of communication difficulties among doctors resulting in their presentation in OH departments with health problems were identified.

Conclusions
Personal health problems caused by poor communication involve considerable time and potential litigation costs. Doctors need to be reminded of their responsibilities. Opportunity cost studies would help to strengthen an evidence base for the need of doctors to adhere to the professional requirements of good communication skills.

Key words
Communication; competency; costs; professionalism.

Introduction
This paper has three parts. It first describes the frameworks and issues surrounding competency in communication skills. Next, the health problems among doctors associated with poor communication and being seen by occupational physicians are identified. Lastly, economic appraisal is considered as a tool to help assess the effects of poor communication among doctors and to help identify preventive strategies.

‘Oh wad some Power the giftie gie us, To see oursels as ithers see us’

Doctors, like other professionals, strive to achieve Robert Burns’ wish expressed in his Ode to a Louse. Towards this objective, the art of good communication is a core component of personal and professional integrity. It has been defined as ‘the use of a common system of symbols, signs and behaviour for the exchange of information’ [1]. ‘Good communication’ is implicit in core values identified by the British Medical Association (BMA) for the medical profession. They include the ‘ancient virtues of competence, integrity, confidentiality, compassion and commitment practised with an enquiring and impartial mind’ [2]. Related qualities include intuition, empathy and rapport [3]. Nevertheless, these time-honoured virtues can be neglected and verbal or written disputes can occur. A recent discussion on the changing role of the
consultant physician, noted for example that, ‘there is clearly an urgent need for clinicians to acquire communication skills and the confidence to share uncertainty with their patients, while retaining their professional integrity’ [4]. In January 2003, with these points in mind, the BMA published a discussion paper: Communication Skills Education for Doctors. It drew attention to ‘barriers to effective communication ranging from personal attitudes to the limitations placed on doctors by the organizational structures in which they work’ [5].

Regrettably, it was reported recently that ‘most complaints against doctors are more to do with attitudinal and behavioural problems, rather than clinical incompetence … They include arrogance, rudeness, poor decision making and judgement, poor communication skills, being disorganized, coping poorly with personal stress and an inability to work as part of a team’ [6]. Doctors are sometimes suspended for communication difficulties [7]. It has even been suggested in a recent American study that despite codes of conduct being in place some nurses leave their profession because of disruptive behaviour by doctors [8]. Doctors are also dissatisfied with their relations with managers [9].

Although it has been reported that ‘scepticism and debate in science is healthy and important’ [10], difficulties in professional communication about scientific matters can be encountered. It has for example been noted that ‘what is still sacrosanct is the capacity for scientists to voice their opinions, perspectives and criticisms of others, be they positive or negative, regarding their own work and that of colleagues’ and that although classical scientific debate can be heated it is ‘libellous to attack a person’s integrity and honesty’ [11]. It has, however, been suggested that: ‘controversy is an inevitable element of medical progress, [although] sometimes it degenerates into doubtful disputations’ [12] and that ‘it seems unlikely that medicine can ever be entirely free of value judgements’ [13].

The poet John Milton implied, however, that disagreement between scientists may have to be accepted. He wrote: ‘give me the liberty to know, to utter and to argue freely according to conscience, above all liberties… Where there is much desire to learn there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making’ [14].

**Is good communication among doctors and with their managers a professional requirement?**

With respect to communication between doctors the General Medical Council (GMC) booklet, Good Medical Practice, states that:

- ‘as a doctor you must … work with colleagues in the ways that best serve patients;
- you must always treat your colleagues fairly. In accordance with the law, you must not discriminate against colleagues;
- you must not make any patient doubt colleagues’ knowledge or skills by making unnecessary or unsustainable comments about them;
- you are expected to work constructively within teams and to respect the skills and contributions of colleagues’ [15].

This guidance is endorsed in the GMC booklets, Maintaining Good Medical Practice [16] and Management in Health Care: The Role of Doctors [17]. The president of the GMC also reiterated in June 2002, that: ‘doctors must work effectively with colleagues’ and that: ‘across the world, doctors are increasingly being held accountable for their actions’ [18].

The GMC has expanded this advice by emphasizing that doctors must be prepared to explain and justify their actions and decisions, not just to patients and their families, but also to colleagues and, where necessary, the courts and the GMC [19]. As the late Sir Douglas Black, a former President of the GMC and former Chief Medical Officer, Department of Health, England, noted in 2002, being a member of a profession entails accepting its duties as well as enjoying its privileges of membership [20]. These duties, as noted by moral philosophers and medical ethicists, have three main components:

- standards of professional competence;
- standards of professional integrity;
- accepted professional procedures [21].

It is reasonable therefore to expect good communication skills to be acquired, retained and utilized in all matters involving communication among doctors and with their medical managers, as well as within clinical teams and with patients. It helps to improve morale among hard-pressed staff [22].

**Does competency in communication skills among doctors and with their managers need to be addressed?**

Inter-related guidance published by the GMC, BMA and Faculty of Occupational Medicine [4,5,18,19,23–26] provides the frameworks for the standards of communication among doctors and with their managers with respect to professional integrity.

Current issues for communication skills include the following:

- An emerging belief that clinical and commercial cultures have become polarized and that co-operative decision making needs to be re-established [27].
A view of the President of the Royal College of Physicians of London that professionalism needs to be looked at again and that ‘we need to affirm our own professionalism as never before. We need to state unequivocally that erosion of professionalism does not just occur from within but is subject to external forces’ [28].

Increasing awareness amongst doctors and health service managers that better collaboration modifies professional behaviour and improves both the efficiency and the quality of services [29,30].

Planning for a joint summit of health service managers and doctors in 2003 ‘to improve understanding between the two professions’ [31].

Understanding that each year the Specialist Training Authority (STA) withdraws recognition for some six Specialist Registrar training posts among which ‘communication difficulties’ account for approximately four withdrawals (STA, personal communication).

The Chief Medical Officer, Department of Health, England, in his lecture to a Risk Management and Clinical Governance conference on 11 March 2002, reported that like plane crashes, medical errors in health care are usually caused: ‘by an amalgam of technical, environmental, organizational, social and communication factors which predispose to human error or worsen its consequences’ [32].

Highlighting at a Department of Health conference on 18 April 2002, ‘Improving Working Lives for Doctors’, of the need for improved communication skills, increased consultation times and better organization to help address: ‘the new imperatives of greater accountability for doctors, the demand for patient-centred care and a growing blame culture’ [33].

Emphasis by Sir Cyril Chantler in the annual Harvevian Oration at the Royal College of Physicians, London, 17 October 2002, that: ‘doctors in the NHS are under great pressure; we need more understanding and less criticism, more trust and less regulation. There needs to be more recognition that errors are usually system, not individual, failures’ [34].

An increase in complaints to the GMC from 1500 in the year 1997 to 4500 in the year 2000, reflecting criticism of doctors and their associated unhappiness [34].

Emerging awareness that the World Health Organization ‘healthy settings’ approach applies to hospitals which are ‘more than a collection of individuals’ [35] and that ‘the high protective effects of high levels of social capital on health are found in ‘communities where there are high levels of trust, participation in civic life and social support’ [36].

Findings from a study of perceptions of the doctor–manager relationship amongst chief executives and medical directors from 197 National Health Service (NHS) acute trusts in Great Britain and a sample of both medical and non-medical managers at the directorate level that clinical directors ‘were the least impressed with management and the most dissatisfied with the role and influence of clinicians’ [37]. Not surprisingly, associated with these issues, newly appointed consultants are seeking formal training in communication and interpersonal skills [38]. They have identified lack of management experience as a specific problem when dealing with difficult colleagues [39]. A recent GMC pilot study of the annual appraisal folders has also identified a lack of underpinning evidence to demonstrate that individual doctors are ‘working with colleagues’ [40]. To help meet the identified needs, communication knowledge, skills and attitudes are now part of the recommendations on the general professional training at the Academy of Medical Royal Colleges required for all trainees [5], assessed in the medical training of the UK Royal Colleges [41,42] and included in annual appraisals and revalidation. Newly qualified junior doctors in the UK will also soon have to undertake a 2 year foundation programme which includes patient safety, high standards of clinical governance and communication and time management skills [43].

Professionalism and the duties of good communication in occupational medicine

In 1997, an Occupational Medicine editorial reported that a profession: ‘is responsible for the setting and maintaining of its own standards and for disciplining those members who are in breach of such standards’ [44]. The journal of the Royal College of Physicians, London, has also reported that ‘as members of a profession, physicians are expected to work collaboratively to maximize patient care, be respectful of one another and participate in the processes of self-regulation’ [45].

Communication is a core component of ‘professionalism’. A study of business ethics in occupational medicine reported that the term implies:

- acquiring and maintaining a recognized competence in specific skills;
- having a sense of dedication and purpose;
- accepting and managing responsibility;
- maintaining autonomy;
- accepting accountability for one’s actions and for the actions of people managed and supervised;
- willingness to collaborate and work effectively with a wide range of other people;
- adhering to an ethical code of conduct;
- practise at all times with personal integrity and for the public benefit [46].
It is also important for professionalism that physicians avoid compromising their public standing and reputation for independence with the general public, peers, colleagues, co-workers and the media [47]. To achieve this, good communication skills are essential.

Towards these aims, the standards of professional integrity for occupational physicians have been addressed. Etiquette, it was noted in an Occupational Medicine editorial, is concerned with good relationships between members of a profession [44]. It was reported there that poor communication ‘can impact on the standard of care we exercise in our day-to-day occupational medicine practices. Jealousy and poor relationships between professional staff can damage the outcome of OH care to the detriment of the working populations which we serve … Dilemmas are difficult to resolve and decisions involving people will always have emotional aspects’ [44]. The BMA has noted, however, that when professional integrity is considered, questions of etiquette and customary practice are often given less attention than other aspects of medical ethics [23]. Yet, medical ethics is a live and changing concept [48,49] and the GMC has reported that doctors need to cope with uncertainty, have the capacity for self-audit and be able to adapt to change [24].

The Faculty of Occupational Medicine (FOM) of the Royal College of Physicians of London has these points in mind. In support of GMC guidance, it has included communication between health care professionals in its ethical guidance for occupational physicians. The FOM has reported: ‘you must not make any patient or employer doubt a colleague’s knowledge or skills … by making malicious, unfounded comments about them … when working in teams you must:

- communicate effectively with colleagues within and outside the team;
- make sure your patients and colleagues understand your professional status and specialty, your role and responsibilities in the team, who is responsible for each aspect of patients’ care and what information will be shared between team members;
- participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies;
- be willing to deal openly and supportively with problems in the performance, conduct or health of other team members’ [25].

A conference held in 1997 at the University of Glasgow opened the debate for standards of professional integrity amongst occupational physicians and measurement of competency in communication skills [50]. A ‘competency’ for occupational physicians was defined there as: ‘the possession of sufficient physical, intellectual and behavioural qualifications (i.e. knowledge, skills, abilities and attitudes) to perform a task or serve in a role which adequately accomplishes a desired outcome’. An audit of communication undertaken at that time between an occupational physician and other medical practitioners confirmed the importance of good communication [51]. Qualitative research methods were also applied to study professional business ethics and personal integrity in occupational medicine practice and help assess problems precipitated by poor communication [46]. The findings were used by the FOM to help establish standards [52].

Competencies that the trainees of occupational medicine are now expected to attain in communication include being able to:

- build rapport, (FOM) listen, persuade and negotiate;
- take responsibility, make decisions and lead with appropriate authority;
- become open, non-defensive, co-operative and empathetic and with a sense of humour;
- be resilient and flexible, able to work under pressure and cope with set-backs and changes [26].

Examples of poor communication between doctors resulting in their attendance at OH departments

Despite expectations of the medical profession, at least within the South West Region, England, doctors are attending NHS OH departments with exhaustion, professional burnout and other stress-related health problems associated with poor communication between doctors and often involving their managers [South West Group, Association of NHS Occupational Physicians (SWANHOPS) 2003, personal communication]. Some of these health problems have precipitated formal complaints by the patients.

The health problems among doctors associated with poor communication and presenting at least twice in one NHS OH department during the 12 months, January–December 2002, and to one consultant occupational physician, were identified by manual retrieval of all doctor–patient records. These cases were anonymized and discussed in 2003 during a 1 h regional clinical audit session. It comprised a focus group discussion among 17 SWANHOPS occupational physicians. They identified nine categories of health problems. The wording of these categories was agreed at the next quarterly regional audit meeting, as follows:

1. the need for reassurance, life skills coaching and structured career guidance to help resolve personal health crises and improve emotional resilience associated with loss of direction in life;
2. poor understanding by medical and other managers of their responsibilities for ensuring health and safety at work and consequent inappropriate supervision of their staff;
3. unwillingness of the senior staff to meet the concerns of junior colleagues about their workplace exposures to pollutants;
4. inadequate advice by senior doctors for recommended personal protective equipment when undertaking exposure prone procedures involving exposure to blood and other body fluids;
5. the health effects on morale, confidence and self-esteem of legal proceedings associated with clinical, management and research activities;
6. failure of managers to explain to persons being referred to the impartial, clinically confidential role of occupational physicians and poor understanding amongst managers and patients of the codes of ethics required of occupational physicians;
7. failure of managers and staff to agree line management responsibilities, reporting structures, workloads, consultation times, chaperoning needs, personal safety requirements and career development requirements/expectations;
8. unwillingness of medical colleagues to accept the clinical needs for a managed return to work;
9. insufficient appreciation by medical managers of the ways work can be modified to accommodate disability.

Doctors as patients represent only about 5% of the case referrals [51]. Nevertheless, they can involve considerable time input costs of NHS occupational physicians. They also support a view that: ‘the most obvious cause of doctors’ unhappiness is that they feel overworked and undersupported’ [53] and recommendations of a Nuffield Trust Partnership that improved communications and support are needed to improve the health of the NHS workforce and to help reduce associated costs of ill health [54].

All these examples of workplace communication problems have resulted in sickness absence of medical staff and associated costs for the health service. They endorse the need identified above from recent general medical literature for improved communication skills as part of the on-going professional integrity, and their role in health and personal morale. But, to help the medical workforce, how should these needs and the standards of communication skills be assessed? Reflective practise such as clinical self-audit, peer-review of case history management, annual appraisal processes with line managers, essay questions and role playing with structured discussion are all used to explore competencies in communication skills among doctors and with their managers. Economic appraisal of occupational medicine case histories could also be explored as a structured, objective method. It seems to have been little studied.

Economic appraisal and preventive strategies

Research has been reported to have only a limited role in deriving health care standards as: ‘governance policies are driven by ideology, value judgements, financial stringency, economic theory, political expediency and intellectual fashion’ [55]. Is it therefore an inappropriate approach to the derivation of standards of communication among doctors and with their managers? Are the research methodologies insufficiently developed? Are the present methods reliable? Should other assessment and measurement tools be considered and utilized? These questions are not readily answered. Nevertheless, the costs of poor communication can be considerable. They include diminished social capital from the:

- time commitment for the doctors and other health care professionals in consultations and the preparation of statements and appearances associated with complaints, grievance and disciplinary proceedings of employers, legal briefings, court and professional hearings, tribunals and/or other disputes;
- time costs of legal proceedings for involved solicitors, barristers, industrial liaison officers and police;
- loss of professional status and employment earnings;
- diminished morale, self-esteem and sense of personal integrity;
- worry and distress to the doctor/any other health care professional implicated and his/her family;
- costs to the employer and state associated with sickness absence and reduced productivity;
- claims for loss of earnings, pain and distress, injury to feelings and reputation and aggravated damages.

Social capital is therefore an important resource [56]. It encompasses the human factors in people of talent, capability, creativity, innovation and knowledge [57]. It also includes the sense of realizing one’s potential and achieving self-fulfilment [58]. What, too, are the time costs for occupational physicians dealing with individual health problems consequent of poor communication? Improved communication could result in considerable cost savings. How might this time be better spent? Opportunity cost studies of the health care manpower issues for what is and could be done with the time should be considered.

Suggestions have been put forward to reduce the social costs. For example, in the investigation of a complaint or claim it has been reported that: ‘resolution of an individual case should include not only financial compensation, where appropriate, but also a clear statement
of what happened, an apology if indicated and details of steps to be taken to try and prevent a similar accident. This would not only improve the medical practice but would help doctors come to terms with the worry and the distress of charges of malpractice… denial, delay and defence do not improve the service to which we are all committed’ [59]. In following up this suggestion, the UK Department of Health now, when a patient suffers adverse health care effects, ‘spells out the importance of analysing “what happened and why”, rather than simply “who got it wrong”’ [60]. Widespread adoption of this approach should help to reduce the number of complaints to the GMC about doctors.

There is also, in seeking to strengthen the values attached to social capital, a legal duty of care to oneself, colleagues, patients and others in respect of a common law negligence and breach of statutory duty. In it, reasonable care must be taken to prevent foreseeable risk from suffering injury [61]. The direct and indirect costs associated with poor communication need therefore to be addressed and as part of valuing preventive measures. The BMA Medical Ethics Team supports this point of view in its recent report that complaints procedures and investigations consume time and money [62]. They drew attention to the importance of avoiding grievances and disputes and conflicts of interest in the rights and responsibilities: the need for sensitivity, honesty, empathy, rapport and intuition and the need to avoid unnecessary distress and possible temporary suspension of a colleague pending investigation through prevention, support and sympathetic reassurance and practical help [62].

The UK Department of Health encourages root cause analysis to investigate the underlying causes of incidents [63]. Human factor analysis has, for example, been applied recently in occupational medicine to investigate eye splash and needlestick incidents and to identify and then address training, cultural and organizational issues in a hospital setting [64]. This approach, linked with cost management data, could be used to study ‘real life situations’ in occupational medicine where poor communication is the root cause of the presenting clinical problem. It would help to strengthen an evidence base for the need to improve present standards of communication among doctors and with their managers.

Conclusions

Communication is a core skill and requires competency in medical practice. Poor standards of communication among doctors and with their managers are therefore unacceptable. Fortunately, a constructive dialogue among them is emerging [65,66]. Problems of poor communication do, however, occur and the consequent health effects are encountered in occupational medicine practice. Doctors need to be reminded of their responsibilities. Widespread adherence of all doctors to the ethical standards expected in communication skills would help considerably to improve professional integrity and to reduce the personal distress occupational physicians encounter in their patients.

There are several ways of assessing the achievement of standards expected in communication skills among doctors. Economic appraisal studies in occupational medicine practice could be included. Other research questions could also be addressed such as how frequently do poor patterns of communication among doctors occur that result in contact with occupational physicians, what clinical and manpower resource effects they have, if there are any patterns to them, might their causal factors be ameliorated readily and, if so, how and what are the ‘best’ preventive interventions? Economic appraisal could include cost savings analysis, cost-containment assessment, cost-effectiveness studies and opportunity cost appraisal from case history scrutiny and economic modelling of problem solving scenarios. There is, however, an equally justified and very human approach in exploring these needs. The concept is commonly described nowadays as ‘investment in social capital’. Formerly, the same ideas were more simply known as ‘helping people to achieve and realize their potential and sense of self-fulfilment’.

At least until there is improved measurement of communication skills and widespread achievement and adherence to competency, doctors and other health care staff will need help to preserve their personal and professional integrity when faced with health problems arising from poor communication in medical practice. Individuals seen in occupational medicine practice can be supported by:

- empathic understanding of their presenting health problems;
- tactful inquiry into the key, often inter-related (i) professional, (ii) career development, (iii) team working, (iv) patient-related, (v) personal, (vi) domestic and (vii) family issues that need to be clarified and managed;
- clear, structured frameworks written out for them outlining the OH, personal and managerial steps needing to be taken to help with (i) their roles at work, (ii) responsibilities, (iii) obligations and duties, (iv) the workplace needs and working patterns expected of them and (v) their plans for career development.

These needs are interdependent. It may also be important to involve the relevant human resources manager, clinical director, industrial liaison officer and/or medical postgraduate dean; their roles should be co-ordinated by the occupational physician.
Undoubtedly, when health problems due to communication difficulties are identified among doctors, occupational physicians can help with personal support of affected individuals. To paraphrase Kipling’s words in his poem If, they can be helped to understand better that: ‘if you can trust yourself when all men doubt you, But make allowance for their doubting too … Yours is the earth and everything that’s in it and—which is more—you’ll be a true professional, my son!’

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