of 25 000 are expected.[1] New legislation may be needed.

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Doctor-patient communication: the Toronto consensus statement

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Effective communication between doctor and patient is a central clinical function that cannot be delegated. Most of the essential diagnostic information arises from the interview, and the physician's interpersonal skills also largely determine the patient's satisfaction and compliance and positively influence health outcomes.[1-3] Such skills, including active listening to patients' concerns, are among the qualities of a physician most desired by patients.[4] Increasing public dissatisfaction with the medical profession is, in good part, related to deficiencies in clinical communication. Studies in many countries have confirmed that serious communication problems are common in clinical practice.

This consensus statement addresses three issues: What are the most important facts we already know about doctor-patient communication? What are the most important things that could be done now to improve the situation? and, What are the most important unanswered questions?

What are the most important facts we already know about doctor-patient communication?

PROBLEMS IN PRACTICE

Communication problems in medical practice are both important and common. For example, 54% of patient complaints and 45% of patient concerns are not elicited by physicians.[5] Psychosocial and psychiatric problems are common in general medical practice, but these diagnoses are missed in up to 50% of cases.[6,7] In 50% of visits the patient and the doctor do not agree on the nature of the main presenting problem.[8,9] In one study patients were interrupted by physicians so soon after they began describing their presenting problems (on average within 18 seconds) that they failed to disclose other significant concerns.[10] Most complaints by the public about physicians deal not with clinical competency problems, but with communication problems,[11] and the majority of malpractice allegations arise from communication errors.[12] Residents or trainees[13] and practising physicians[14] have shown substantial deficiencies when studied. Only a low proportion of visits with doctors include any patient education,[15] and a surprisingly high proportion of patients do not understand or remember what their physicians tell them about diagnosis and treatment.[16] Cultural differences also impede the work with patients.[17,18]

Patient anxiety and dissatisfaction is related to uncertainty and lack of information, explanation, and feedback from the doctor. Yet doctors often misperceive the amount and type of information patients want. The language doctors use is often unclear, both as regards the use of jargon and in relation to a lack of the expected shared meanings of relatively common terms.[20-23]

COMMUNICATION PRACTICES IN RELATION TO OUTCOMES

The quality of clinical communication is related to positive health outcomes.[24,25] Reduction in blood pressure was significantly greater in patients who, during visits to the doctor, had been allowed to express their health concerns without interruptions.[26] Concordance between physician and patient in identifying the nature and seriousness of the clinical problem is related to improving or resolving the problem.[5,9,27]

Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant fall in anxiety.[28] Greater participation by the patient in the encounter improves satisfaction and compliance[1] and outcome of treatment (for example, control of diabetes and hypertension).[24] The level of psychological distress in patients with serious illness is less when they perceive themselves to have received adequate information.[29,30]

Beneficial clinical communication is feasible routinely in clinical practice and can be achieved during normal clinical encounters, without unduly prolonging them, provided that the clinician has learned the relevant techniques.[31,32]

EDUCATIONAL ISSUES

To become effective communicators, physicians

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must master a defined body of knowledge, skills, and attitudes.[33] Clinical communication skills do not reliably improve from mere experience. Examples of relevant areas of knowledge are psychiatry in relation to medicine (for example, diagnostic clues to depression, anxiety, somatisation problems) and the structure and functions of medical interviewing. Examples of skills needed within the interview are those of data gathering, forming and maintaining relationships, dealing with difficult issues (such as sexual history, breaking bad news, HIV), and imparting information; therapeutic skills and strategies are also necessary.[34-38] These skills can be defined with behavioural criteria and can be reliably taught and assessed.[34 39 40] Helpful attitudes include a belief in the importance of a biopsychosocial perspective[41] as well as an unconditional positive regard for patients.[42] A physician's personal growth and self awareness are essential bases of effective communication.

Unfortunately, traditional medical education at all levels is generally ineffective in teaching clinical communication.[43-45] Medical education is a stressful and sometimes abrasive experience that can produce cynicism and callousness.[46] Surveys of American and British medical schools showed that, although some important advances have occurred, there is extensive variability in the quality and intensity of courses offered.[47 48]

Much is known about the elements of an effective course on clinical communication. Highly structured programmes, in which specific skills are identified, demonstrated, practised, and evaluated, tend to be more effective than less structured programmes.[49 50] Courses should include faculty development, quality control of teaching, and relatively low student to teacher ratios, providing students with multiple opportunities for practice and feedback. Use of videotape and audiotape reviews, role play, and standardised patients have been proved to be effective tools.[33 40] Communication skills training should be taught at all levels of the curriculum: further development of skills is needed as students encounter more complex situations, and interpersonal skills, like other skills, benefit from reinforcement.[51] Such training can be enhanced by partnership between clinicians and others —for example, behavioural and social scientists. The effects of such training on specific skills can persist over time[52 53] and this effect is likely to be greater if there is coordination of teachers and courses at all levels. Coherent attention needs to be given to students' emotional issues, such as working with dying patients and anger at self inflicted ill health.[54 55] Balint groups and other support and discussion groups have proved useful in this context.[56 57]

Few medical education programmes require demonstrations of competency in communication for graduation or certification. Though further development of valid and reliable assessments of communication competencies is anticipated[58] communication skills can already be assessed with useful accuracy with current evaluation techniques[59] to establish minimal standards of competence.[60]

Each institution therefore requires faculty members capable of leading education for each clinical stage. The field of doctor-patient communication needs faculty development. The faculty development approach of the American Task Force on the Doctor and Patient combines didactic skills, learning skills, practice, task orientation, and a focus on personal response to the work and is an effective model. Another model with documented efficacy is the Manchester approach, which uses videotape feedback to prepare British general practice trainers to teach communication skills to their trainees.[37] Faculty members need access to training in research methods.

What are the most important things that could be done now to improve clinical communication by doctors?

Physicians should first encourage patients to discuss their main concerns without interruption or premature closure. This enhances satisfaction and efficacy of the consultation—yet, contrary to the expectation of many doctors, this need not take long: a maximum of 2½ minutes, or an average of 90 seconds.[10] Doctors should also strive to elicit patients' preceptions of the illness and associated feelings and expectations.[17 61-65]

Experience also supports the value of learning methods of active listening and empathy.[39 41 42] The appropriate use of open ended questions, frequent summaries, clarification, and negotiation are factors that positively affect the quality and quantity of information gathered; factors with a negative impact include inappropriate use of closed ended questions and premature advice or reassurance. Other important skills include giving clear explanations, checking the patient's understanding, negotiating a treatment plan,[66] and checking patients' attention to compliance.[67]

To promote acquisition of these skills, facilities for videotaping and audiotaping and reviewing consultations should be provided. Institutions should consider requiring and facilitating such skills training with medical schools, hospitals, and private practices and within existing journal clubs, courses, and continuing medical education programmes. Licensing and specialty qualifying authorities should require proof of competence in clinical communications.

What are the most important unanswered questions and priorities?

QUESTIONS ABOUT CLINICAL ENCOUNTERS

What are the specific elements of communication that maximise patient satisfaction, collaborative autonomy, quality of life, enhancement of coping, and adaptation and recovery or rehabilitation while minimising conflict and litigation? Although a great deal is known about the early phases of the interview, less is known about information exchange and therapeutic strategies.

What physician, patient, family, and practice variables affect the encounter, and how do they interact? For example, what specific personal qualities of the physician are most influential? What patient attitudes, preferences, and beliefs are most important? How do health care and payment systems influence communication practices—and how should they be designed so as to optimise communication?

Relationships may vary according to the degree of control and involvement the patient prefers.[68] What are the influential dimensions and mechanisms of effective active participation by patients?

How do communication needs and practices vary in the course of continuing clinical care? Also, we need to explore the ethical aspects of communication and communication aspects of ethics.

QUESTIONS ABOUT EDUCATION ISSUES

A wide range of effective teaching methods and media have been developed—which are most effective and efficient for teaching which skills and strategies?

How does the stage of training or clinical experience of the learner affect optimal teaching methods and sequencing? How can teachers most effectively help learners identify their resistances to learning to encounter the full extent of their patients' problems, and how can such resistances be overcome?

Are all communication skills teachable? Which skills are the most and least teachable? How can students' learning styles be best assessed so that training can be most effectively tailored to individual needs?

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How can educational, health care, and reimbursement systems be best adapted so as to motivate and reward faculty or trainers and practitioners to learn and teach these skills?

How can doctors best continue to develop their skills, apply them within their daily work, survive emotionally, and feel more satisfied? How can persistent behavioural, 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.

QUESTIONS ABOUT RESEARCH METHODS

Complementary development of alternative methods will allow the identification and description of aspects of clinical communication not already recognised or studied. Qualitative methods need to be encouraged, to complement the now standard quantitative and interaction analysis measures.

Conclusion

Sufficient data have now accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management. It has been repeatedly shown that the clinical skills needed to improve these problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. There is therefore a clear and urgent need for teaching of these clinical skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education. If current knowledge is now implemented in clinical practice, and if the priorities for research are addressed, there may be material improvement in the relationship between patient and doctor.

The three major topics of this statement were circulated to panel members and speakers, and their collated responses were recirculated. The preliminary draft of this statement was prepared immediately before and during the conference, and a final draft produced at a forum of all participants. The consensus panel was chaired by M Stewart.

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