



---

# Communication Skills in Patient-Doctor Interactions: Learning from Patient Complaints

Janine W.Y. Kee <sup>a</sup>  , Hwee Sing Khoo <sup>b</sup>, Issac Lim <sup>b</sup>, Mervyn Y.H. Koh <sup>c</sup>

Show more 

 Outline |  Share  Cite

---

<https://doi.org/10.1016/j.hpe.2017.03.006>

[Get rights and content](#)

Under a Creative Commons [license](#)

[open access](#)

---

## Abstract

### Purpose

Despite communication skills training in medical school, junior doctors continue to demonstrate poor patient-doctor communication skills, where patient unhappiness from the encounter often manifests as patient complaints. We sought to identify crucial communication skills that should be incorporated in the communications curriculum by learning from patient complaints, to explore how the communication lapses occur.

### Method

38 cases of anonymized negative patient feedback about junior doctors were analysed using qualitative content analysis. A two-step fine-coding system involving four researchers was employed.

### Results

Four main themes of communication errors were identified, namely: non-verbal (eye contact, facial expression and paralinguistic), verbal (active listening and inappropriate choice of words), and content (poor quantity and quality of information provided); and poor attitudes (lack of respect and empathy).

## Discussion

Patient-doctor communication is a complex interpersonal interaction that requires an understanding of each party's emotional state. We identified important but overlooked communication lapses such as non-verbal paralinguistic elements that should be incorporated into communications curriculum, with an emphasis on dialectical learning. These include integrating these findings into a simulation-based communications module for training doctors at a post-graduate level as well as monitoring and analyzing patient complaints regularly to iteratively update the content of the training module. Beyond these skills training, there is also a need to highlight negative emotions of doctors in future research, as it influences their communication patterns and attitudes towards patients, ultimately shaping how patients perceive them.



## Keywords

Communication skills training; Patient complaints; Patient negative feedback; Patient-Doctor communication; Residency training

---

## 1. Introduction

Doctor-patient communication is a fundamental component of clinical practice. In addition to being knowledgeable scientific experts in various specialties, effective doctor-patient communication is required for building a therapeutic doctor-patient relationship.<sup>1</sup> In recent years, a growing emphasis on patient autonomy, patient-centered care, consumerism in medicine has further exemplified the importance of effective doctor-patient communication.<sup>2</sup> Despite this, good doctor-patient communication remains a challenge for physicians, and is the underlying reason for the major part of patient complaints.

---

There has been a renewed interest in communication skills in graduate medical education.

---

adherence to treatment plans, reduces work-related stress and burnout for doctors, and leads to positive effects on health care costs, including decreased diagnostic tests, referrals, and length of hospital stay.<sup>5, 6, 7, 8</sup>

On the contrary, a breakdown in the doctor-patient relationship often manifests as unsatisfactory patient-doctor communication, the dominant theme in malpractice claims.<sup>9, 10</sup> This could be related to the contrasting perspectives by patients and doctors on what constitutes effective communication. Patients prefer a psychosocial model of communication compared to a biomedical model, which is used more commonly by doctors.<sup>11</sup> Doctors also tended to overestimate their communication abilities. A survey conducted by the American Academy of Orthopedic Surgeons demonstrated that 75% of orthopedic surgeons surveyed believed they had communicated satisfactorily with their patients, compared to only 21% of patients.<sup>12</sup> Even though possessing verbal intelligence assists one in communication responses during unfamiliar situations, the effect of verbal intelligence ceases after one undergoes professional training in communication skills.<sup>13</sup> This highlights the importance of implementing a relevant communications curriculum to maintain an acceptable standard of patient-doctor communication for junior doctors.

Prior research on patient complaints focused on documenting the frequency of complaints, complainant demographics, and categorizing broadly the nature of these complaints into categories such as billing, treatment, diagnosis, efficiency, operational systems, poor attitudes, and communication.<sup>14, 15, 16, 17</sup> Specific communication skills such as poor attitudes and insufficient information provided were highlighted as part of some studies' sub-group analysis.<sup>14, 18, 19, 20</sup> However, these general themes do not elucidate the types of communication errors that led to patient dissatisfaction and eventual complaints.

In this paper, we sought to illuminate the communication lapses more deeply by investigating the communication errors made by junior doctors during doctor-patient encounters through a rigorous qualitative analysis of complaints submitted by patients and their families.

We chose to focus on junior doctors in patient complaints for the following reasons. First, despite receiving communication training during medical school, many junior doctors continue to demonstrate poor patient-doctor communication skills in areas such as breaking bad news, and found patient-doctor communication a challenge.<sup>21, 22, 23</sup> Second, patient complaints are a valuable source of updated and prognostic information, possibly guiding successful interventions that can be implemented to improve the quality of care.<sup>24, 25</sup> In addition to providing a balanced perspective through incorporation of the patient's view, aligning the curriculum and training of junior doctors with the analysis of patient

complaints presents the opportunity to adjust behaviors, better manage and understand patient perspectives, and hopefully reduce patient complaints. These findings could be integrated into curriculum emphasizing dialectic learning, where junior doctors may learn real-life patient scenarios from what their peers and mentors have experienced, through the examination of different perspectives and arguments.

## 2. Method

### 2.1. Healthcare-system context

This study involved a retrospective review of patient feedback records from a large 1500 bed hospital in Singapore. Patient feedback is collated by the hospital's Office of Clinical Governance (OCG)'s Management Information Department provided through various mediums including emails, written feedback forms, and phone calls. In 2013, the hospital received an average of 2660 patient feedback each month. Of the feedback received, an average of 9.3% (246 per month) was complaints.

### 2.2. Data collection

125 cases of patient complaints against doctors between March 2013 and February 2014 were retrieved from OCG for retrospective analysis, of which 38 were identified as complaints specifically against junior doctors (house officers, medical officers, and residents). All data provided to the research team was fully anonymized, with no patient and physician identifiers. Emails and written feedback were provided to the research team in the written text format, while patient complaints via phone calls were recorded in the form of written content transcripts by the staff that received them, and provided to the research team. Ethical approval for this study was attained from the cluster Institutional Review Board, National Healthcare Group Domain Specific Review Board (NHG DSRB) (NHG DSRB Ref: 2014/00823).

### 2.3. Data analysis

We sought to understand the patient feedback from a dialectical constructivist perspective<sup>26</sup>, guided by the question: What are the communication issues from negative patient-doctor interactions that could be addressed in physician education or training? Dialectical constructivism is based on the belief that knowledge is acquired from the interaction between the person and the environment.<sup>27</sup> Important communication issues arising from negative patient-doctor interactions could be integrated in curriculum emphasizing dialectic learning, where “scaffolding” is provided in the form of vicariously learning, and then practicing real life scenarios with peers and mentors.<sup>28</sup>

Together with qualitative content analysis that is aimed to “provide knowledge and

understanding of the phenomenon under study”,<sup>29</sup> they serve as a suitable approach to our study as patient complaints are inherently interactional processes built upon differing perspectives, and predominantly expressed as vignettes, reflecting multiple learning scenarios for junior doctors. The qualitative content analysis process involves close examination of the text content to arrange a large amount of text into classifications corresponding to similar meanings in a parsimonious manner.<sup>30</sup> The Microsoft Excel software was used to assist the coding process. A two-step fine coding system was used where two researchers developed codes inductively from the feedback responses, and fellow coders joined the discussion at the second stage to finalize the codes. At the first stage, two researchers (JK & KHS) from the team conducted open coding independently where disagreements were discussed at joint coder meetings every couple of weeks along the coding process. This enabled the development of a shared understanding of concepts as well as the properties and dimensions of the codes. Our coding process similarly embodied dialectical learning; each complaint vignette was debated about from the perspectives of physicians and laypersons as per the identities of our researchers (JK & KHS) to enhance understanding about the context and issue. At the second stage, fellow researchers (IL & MK) participated in the discussion of the categorization of the concepts that emerged during the open-coding process. This allowed the researchers who participated in the second stage to provide unbiased opinions on the concepts and themes that emerged from the open coding process.

As new concepts emerge during the coding process due to our coding design involving joint coder meetings, and themes were also not predetermined before the study, it is not viable to measure inter-rater reliability in the usual way during stage one of the coding process. At the beginning of stage two, a pre-discussion consensus estimate of inter-rater reliability (77.8% percent agreement) was attained between researchers IL and MK regarding their extent of agreement with the themes that emerged during stage one’s coding by JK and KHS. Following that, the team discussion resolved varying opinions and finalized the coded themes. The two-step fine coding design also handled researcher bias issues as multiple perspectives were consulted for the coding process. Incorporating investigator triangulation with a coding team comprising both medical professionals and laypersons allowed a deeper understanding of the data, augmenting our confidence in our analysis.<sup>31,32</sup>

### 3. Results

#### 3.1. Overall results

We identified four general themes and nine sub-themes from our analysis of patient complaints ( $n=38$ ) against junior doctors. [Table 1](#) presents an overview of the themes identified. More than one sub-theme may be identified from each patient complaint. The

most commonly identified theme was poor attitudes, followed by content of information communicated, non-verbal, and verbal communication errors.

**Table 1.** Overview of communication errors made by doctors.

<b>Themes and sub-themes regarding the nature of communication errors</b>	<b>Number of complaints</b>
<b>Non-verbal communication errors</b>	
Eye contact	2
Facial Expression	5
Paralanguage	4
<b>Verbal communication errors</b>	
Active Listening	2
Inappropriate Choice of Words	7
<b>Content of Information Communicated</b>	
Inadequate information (poor quantity of information)	7
Poor quality of information	9
<b>Poor attitudes</b>	
Lack of Empathy	14
Lack of Respect	12

## 3.2. Non-verbal communication skills

### 3.2.1. Eye contact

A lack of eye contact, inadvertently through the increasing and widespread use of technology can lead to communication errors. This was exemplified in the following excerpt: *“He didn’t check on me at all, and merely check(ed) his screen for an appointment to arrange for a CT scan... “(Patient feedback 1).*

### 3.2.2. Facial expression

A negative facial expression leads to doubts about a doctor’s capabilities, and feelings of frustration and anger from the patient. For example, one patient commented that: *“... (His)*

*face (was) black like charcoal. What (kind of) a doctor is (he)? Please take the above seriously; (otherwise) he will spoil the reputation of...* (Patient feedback 31).

In addition to overt negative facial expressions, patients also took notice of subtle expressions that implied disinterest. Based on these observations, interpretations about physicians' attitudes to care were made. "... When I approached him, he look(ed) at me, (as if he was) not happy, what (kind of) doctor is this? I hope he can change his attitude." (Patient feedback 30).

Even though patients acknowledged difficulties faced by doctors in their jobs, doctors were expected to contain their own negative emotions. In this scenario, a lack of facial expressiveness conveyed a message of poor personalized care. "I understand that doctors are very busy in their daily work, but it's always a different experience for each and every patient. The least that the doctor can do is not express their weariness to her patients" (Patient feedback 3).

### 3.2.3. Paralanguage

Paralanguage describes non-verbal communication between people, bringing attention to the importance of "how" words are said. It includes prosodic features such as volume, pitch, intonation, rhythm, and speed; which accompany speech, but are not considered part of the language system.<sup>33</sup> Voice intonation and volume were identified in our analysis.

In this example, a physician's expressionless tone led to the patient feeling that personalized care was not being delivered. "Although I spoke to her nicely, (she) responded with an inhospitable attitude... She advised me... to keep (it) clean in a very flat and tired tone that obviously showed that she was bored with advising the same words to many patients before me..." (Patient feedback 3).

The volume used by physicians when speaking to their patients was also highlighted as an important aspect of communication. After raising her voice at a patient on two separate occasions, a negative impression of the physician was formed. This patient described, "She is (the) worst doctor I (have) ever met in my life. She yelled at (me) twice on two different days" (Patient feedback 15).

## 3.3. Verbal communication skills

### 3.3.1. Active listening

Patients' relatives reported doctors failing to answer their questions, and instead of addressing their concerns, doctors proceeded to ask other questions important to them. One such example included: "When (we) asked how the patient was doing, (the) doctor only questioned if we were unaware of the patient's history." (Patient feedback 21).

Patients were also not given a chance to ask questions, and when they finally managed to do

so, they were interrupted. This led to a breakdown in communication, with patients feeling unacknowledged. *“She talked without any notable pause to allow questioning. She was not interested to focus on listening or pay close attention to (the) questions asked, (and) when I was finally able to ask, she was always cutting me (off) while I was in the middle of asking or explaining my concerns, resulting in (her) not answering my actual concerns” (Patient feedback 5).*

### 3.3.2. Inappropriate choice of words

Physicians were described as speaking in a brusque and threatening manner. In this example, a doctor who was on a busy night shift responded tactlessly when speaking to concerned relatives. Her reply lacked sensitivity towards their feelings. *“She is insensitive and said something like, “I am (the) on call doctor. I don’t know the patient. I just came here to check (on the) patient, so that they won’t die!” Overnight, if you are the patient’s family member, what and how will you react?” (Patient feedback 37).*

Another patient described a situation where she received conflicting instructions regarding the need for an abdominal radiograph from a nurse and a doctor. When she approached the doctor, he denied being the cause for the error. Instead of seeking to clarify the situation, he persisted in uncovering the identity of the nurse. He repeatedly asked the patient, *“which nurse”* in an *“unfriendly tone”*, and when the patient was unable to recall the identity of the nurse, he even *“challenged”* her to bring a pen and paper to the hospital in the future to document the identities of all healthcare workers she speaks to; in order to avoid further confusion. The patient concluded that the doctor not only demonstrated poor attitude, but also lacked professionalism. *(Patient feedback 35).*

## 3.4. Content of information communicated

### 3.4.1. Inadequate Information (i.e. poor quantity of information)

Doctors were expected to provide detailed explanations to their patients regarding their investigation results and management plans. *“Very upset and disappointed with your doctor ... didn’t explain (the) MRI results in detail. (I) had to keep probing. (I) have seen many better doctors before. She didn’t seem to know her job at all!” (Patient feedback 1).*

In this other example, a doctor proceeded to make arrangements for a patient to undergo surgery without providing them with the needful information. *“She needs to learn not to barge in on (an) oblivious patient and deliver the news of her actions (she had) taken, booking the appointment for (the) surgery, before telling them the test results, findings, implications and most important of all, the available options” (Patient feedback 5).*

Other patients reported being *“upset with the lack of updates”*, and that their doctor *“did not explain anything in the report”*. They also expected their doctors to be *“information engaging”*



(Patient feedback 2, 17, & 36).

### 3.4.2. Poor quality of information provided

We highlight several examples of patients being dissatisfied with their doctors for not explaining the rationale behind their recommendations. A patient with pain around his stitches was referred to the polyclinic, a government subsidized primary healthcare clinic, but was not told why. Unless there are major complications, this would be the standard of care in our setting. *“(I have) pain around the forearm with (the) stitches, and (I) still feel the pain at the present moment, but Dr. X. referred me to the polyclinic.”* (Patient feedback 11).

In this other example, a relative received inadequate explanation as to why a blood test that was performed last week at the polyclinic was not repeated. *“My dad had a blood test done at (the) polyclinic a week ago. Seeing (that) his condition was weakening, I came for a consult. Dr. X. did not do a blood test to check (on) his present condition and instead mentioned that it was his baseline.”* (Patient feedback 19).

### 3.5. Poor attitudes

Attitudes are the relatively enduring organization of beliefs, feelings and behavioral tendencies towards objects. It comprises three components, namely affective (emotional response towards an object), cognitive (factual knowledge of an object) and behavioral (behavior towards the object)<sup>34</sup>.

#### 3.5.1. Lack of empathy

An important theme that emerged from our analysis was the lack of empathy. Doctors failed to demonstrate an understanding of patient's suffering and were described as “*not human*”, “*insensitive*” and needed to be “*more caring*” (Patient feedback 33, 37 & 36). In this example, the doctor failed to appreciate the nature of the patient's occupation and how the illness affected his/her ability to return to work. *“Your doctor is very unfriendly, I asked for more days of Medical Certificate (medical leave) because of my work but she was not empathic and talked to me as if I am lazy”* (Patient feedback 10).

Doctors were also expected to be empathic towards caregivers. In this scenario, the doctor assumed that the patient's spouse would be a suitable caregiver: *“Don't ever judge anyone and say (that) the individual appears to be fine to care for a paralyze(d) patient... XXX needs to train doctors to be compassionate, tactful and check my mother's medical history before thinking she can care of my father for now!”* (Patient feedback 4).

#### 3.5.2. Lack of respect

Doctors were described “*rude*”, and failing to respect their patients as fellow human beings.

Patients inferred that they were not respected based on different communication errors. For example, on the basis of lacking sufficient content: *“He does not respect the patient at all, did not explain anything (on) the report, (and) even did not want to see patient” (Patient feedback 17).*

And in the context of paralanguage and inappropriate choice of words used: *“The way Dr. X sees my parents is not professional, very rude! The way he speaks is unacceptable ... It is threatening” (Patient feedback 18).*

Disrespect was also highlighted in specific situations. For example, when doctors failed to introduce themselves to their patients or seek permission from patients for medical students to be involved in their care (Patient feedback 37), and when desirable attitudes towards their patients were only displayed in the presence of a senior clinician. *“Dr. X who was consulting my father... (Was) very rude, very unhappy, very impatient, lack(ed) patient care, showing bad attitude (and) show(ed) professionalism only when senior consultant arrived.” (Patient feedback 16).*

#### 4. Discussion

In this study, we identified communication issues arising from the negative interactions of junior doctors and patients. This included specific non-verbal and verbal communication errors, content errors, as well as poor attitudes. Along with these communication issues, we identified a myriad of associated factors including negative emotional spillover, technology use and inter-professional practice. We believe that patient complaints provide a rich source of dialectic learning for junior doctors, being person-context scenarios that doctors need to manage judiciously through the entire course of their careers.

Our findings highlighted crucial but often overlooked non-verbal communication skills such as facial expression and paralanguage. Non-verbal communication is widely recognized as conveying affective and emotional information. where studies have shown that facial expressions are reliable indicators of a person's emotion.<sup>35</sup> For example, a frown conveys disapproval while a smile conveys agreement. A blank expression also conveys affective messages such as aloofness and boredom.<sup>36</sup> However, a negative facial expression e.g. frowning does not necessarily equate a negative outcome when communicating with patients. A study of physical therapist's non-verbal communication demonstrated that composite facial expressions of smiling, nodding and frowning were rated positively by geriatric patients as it conveyed concern, empathy and warmth; and was associated with short and long term improvements in functioning. Conversely, looking away and not smiling conveyed indifference and distancing.<sup>37</sup> As such, it may not be doctor's negative or positive facial expressions that patients focus on, but rather facial expressiveness.

The need to convey expressiveness through paralanguage is also evident from our study results. A flat and tired tone conveys feelings of disregard and boredom. Doctors who speak

smoothly and clearly with proper intonation of vital content and engage with an appropriate diversity of volume are perceived as more competent compared to those who speak monotonously.<sup>38</sup> This also brings to attention the emotion spillover effect, where patients were affected by the negative emotion spillovers from the physician, which they highlighted in their feedback. The spillover effect has been documented in research exploring spillover in moods from workplace to home but less so on the patient-doctor relationship.<sup>39</sup>

The lack of eye contact, negative body posture and insufficient information provided by doctors have been linked to the use of consulting room computers.<sup>40, 41</sup> In our study, all of the complaints relating to the lack of eye contact were associated with computer use. The ability to maintain eye contact with a patient is crucial, as gaze serves to convey interest in a person and facilitate information gathering. On the contrary, screen gaze is disruptive to psychosocial enquiry and emotional responsiveness from the doctor.<sup>42</sup> Technology impacts doctor-patient communication both negatively and positively, where for instance, information technology enhanced patient education sessions by allowing doctors to readily retrieve educational diagrams from the Internet, and medical information such as medication lists and investigation results from patient records.<sup>43, 44</sup>

We identified scenarios in which doctors demonstrated poor listening skills. Instead of listening intently and answering questions posed by patients and their relatives, doctors interrupted them and proceeded with their own agendas. In addition, listening involves more than simply comprehending what is posed. It involves an appreciation of what was expressed and requires one to listen discriminately and empathically beyond the content into the emotions of the speaker in order to appreciate their point of view, before one can subjectively experience and share their psychological state.

Doctors also lacked initiative in providing timely updates to their patients about their clinical condition and investigation results. There was a lack of shared decision-making, and arrangements were made to proceed with investigations without prior discussions. Much literature has been published about shared decision-making and truthful detailed discussions when pathology is present especially in the context of cancer.<sup>45, 46</sup> In our study, we observed that patients expected detailed explanations not only when pathology is present, but also in scenarios with normal results or minor ailments, as perceived by the doctors. Doctors also needed to explain their decision making process behind their proposed management plans. This was especially so in situations when patients could potentially perceive their needs as not being appropriately addressed. For instance, when a diversion of care was made from a tertiary hospital to primary care, or when their requests for medications or investigations are declined. As our study was conducted in a public subsidized health care setting, these scenarios were common.

In our findings, doctors demonstrated poor respect and empathy for their patients. There

is a two-way relationship between attitudes, behaviors or emotions. Attitude determines how one behaves or feels towards others. Likewise, based on behaviors and emotions displayed, we can determine one's attitude. Results from our study suggest that patients made conclusions about how respectful doctors were based on their non-verbal and verbal communication skills. A previous study by Beach et al. demonstrated that the amount of respect doctors had for their patients were related to the amount of information they shared, where positive global affect towards patients led to more positive non-verbal behaviors including nodding, smiling and eye contact. Patients were also shown to be accurate in deciphering the amount of respect their doctors had for them, as discussed in our results regarding patient sensitivity about respect.<sup>47</sup>

The relationship between inter-professional communication and patient-doctor communication was also apparent during our examination of the patient complaints. In several scenarios, poor communication between doctors and their fellow colleagues or another health care professional such as a nurse or social worker contributed to eventual poor patient-doctor communication. This is expected as inter-professional communication promotes the sharing of knowledge and skills between professional individuals with different expertise. This allows for shared-decision making between the professional individuals and an eventual unanimous management plan for the patient where inter-professional based care and communication leads to better patient outcomes and satisfaction.<sup>48, 49</sup>

#### 4.1. Limitations and future research

The main limitation of this study was that our data presented us with only the patient's perspective. We mitigated this during the data analysis process by assembling a coding team made up of physicians and laypersons. Our analysis contributed to the extant literature on findings such as the role of information technology, a lack of inter-professional communication and systemic logistical constraints faced by doctors. Other challenges faced by doctors in today's healthcare include unrealistic workloads, fatigue, and feelings of being undervalued and disillusioned.<sup>50</sup> Further studies need to be conducted to understand how these factors affect patient-doctor communication.

It should also be noted that our data represents opinions from a certain subset of patients as not every patient who is displeased with care received by the hospital would choose to lodge a complaint via formal channels.

This study made a number of important contributions by allowing a deeper understanding of the gap between effective doctor and patient communication, providing valuable input of vital content for the training of junior doctors. The doctor's explanation should be provided at a suitable level for the patient to allow an accurate interpretation and assimilation of the information. The doctor is also expected to display good non-verbal

skills, speak at an appropriate speed, maintain an engaging tone of voice, and continuously display good body language that reflects genuine interest in the patient. Patients also expect doctors to remain respectful and empathic towards them; and to be aware of their own emotions as well as the patient's emotions.

Patient-doctor communication is a complex interpersonal interaction that requires an understanding of the other party's emotional state. As such, it is important to increase doctor's awareness about how their negative emotions can affect patients as it impacts their verbal, non-verbal and content communication patterns, their attitudes towards patients, and how patients ultimately perceive them. This could be addressed by including training content related to self-awareness, and how negative emotions spillover affects other parties in the communication skills curricula. Further research in this area will need to be conducted.

## 4.2. Implications

Through our qualitative analysis, the tangible information about communication errors made by junior doctors derived from direct patient feedback could be contextualized into rich discussion points in communication skills training modules for young doctors.

Incorporating blended learning strategies into a curriculum caters for learners with different learning styles, and allows for suitable teaching strategies to be used to achieve particular learning outcomes.<sup>51,52</sup> For instance, these research findings can first be shared with junior doctors to foster an understanding of the relevance of training module on their future job performance and patient satisfaction. Relevance provides learners with realization of its usefulness and is essential for effective teaching.<sup>53</sup> Subsequently, communication scenarios are practiced in small groups with each individual taking turns to practice in the presence of peers or faculty. Discussion of each individual's performance can be guided by these communication themes identified from patient feedback. This learning activity incorporates a variety of learning pedagogies including experiential learning, reflective practice, social and adult learning.<sup>54,55</sup>

Another intervention could involve the use of blended classroom strategies whereby research findings will be shared on an on-line platform or in the form of a pre-reading.<sup>41</sup> Learners subsequently attend tutorials where anonymized case scenarios crafted from actual negative patient feedback letters are discussed. This will encourage learners to demonstrate understanding and application of evidence based curriculum that was learnt online. Case discussions led by clinical teachers will encourage a triangulation of opinions, further challenging and enhancing the depth of individual perspectives, and the overall learning experience.

Trends in patients' negative feedback should continue to be monitored for other

communication issues that can be included in the curriculum to ensure continued relevance and applicability of the communication skills training modules.

## Disclosure

Ethical Approval: Ethical approval for this study was granted from the cluster Institutional Review Board, National Healthcare Group Domain Specific Review Board (NHG DSRB) (NHG DSRB Ref: 2014/00823).

## Funding

None.

## Other disclosure

None.

## Acknowledgements


The authors would like to thank Group Chief Education Officer of National Healthcare Group Associate Professor Nicholas Chew Wuen Ming and Tan Tock Seng Hospital's Office of Clinical Governance for their support of this study.

[Recommended articles](#)

## References

- 1 J.F. Ha, N. Longnecker  
**Doctor-patient communication: a review**  
Ochsner J, 10 (1) (2010), pp. 38-43  
[View Record in Scopus](#) [Google Scholar](#)
- 2 A.K. Shukla, V.S. Yadav, N. Kastury  
**Doctor-patient communication: an important but often ignored aspect in clinical medicine**  
J Indian Acad Clin Med, 11 (3) (2010), pp. 208-211  
[View Record in Scopus](#) [Google Scholar](#)
- 3 S.G. Henry, E.S. Holmboe, R.M. Frankel  
**Evidence-based competencies for improving communication skills in graduate medical education: a review with suggestions for implementation**  
Med Teach, 35 (5) (2013), pp. 395-403



- 4 S. Dorr Goold, M. Lipkin  
**The doctor-patient relationship: challenges, opportunities, and strategies**  
J Gen Intern Med, 14 (Suppl 1(MI)) (1999), pp. S26-S33  
[Google Scholar](#)
- 5 K.B. Haskard-Zolnierrek, M.R. DiMatteo  
**Physician communication and patient adherence to treatment: a meta-analysis**  
Med Care, 47 (8) (2009), pp. 826-834  
[View Record in Scopus](#) [Google Scholar](#)
- 6 A.J. Ramirez, J. Graham, M.A. Richards, A. Cull, W.M. Gregory  
**Mental health of hospital consultants: the effects of stress and satisfaction at work**  
Lancet, 347 (9003) (1996), pp. 724-728  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 7 P. Little, H. Everitt, I. Williamson, *et al.*  
**Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations**  
BMJ., 323 (7318) (2001), pp. 908-911  
[View Record in Scopus](#) [Google Scholar](#)
- 8 K.D. Bertakis, R. Azari  
**Patient-centered care is associated with decreased health care utilization**  
J Am Board Fam Med, 24 (3) (2011), pp. 229-239  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 9 B. Huntington, N. Kuhn  
**Communication gaffes: a root cause of malpractice claims**  
Bayl Univ Med Cent Proc, 16 (2) (2003), pp. 157-161  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 10 W. Levinson, D.L. Roter, J.P. Mullooly, V.T. Dull, R.M. Frankel  
**Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons**  
JAMA, 277 (7) (1997), pp. 553-559  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 11 D.L. Roter, M. Stewart, S.M. Putnam, M. Lipkin, W. Stiles, T.S. Inui  
**Communication patterns of primary care physicians**  
JAMA., 277 (4) (1997), pp. 350-356  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)

- 12 J.R. Tonge, H.R. Epps, L.L. Forese  
**Communication skills for patient-centered care**  
J Bone Jt Surg, 87-A (3) (2005), pp. 652-658  
[Google Scholar](#)
- 13 J. Kuntze, H.T. van der Molen, M.P. Born  
**Mastery of communication skills. Does intelligence matter?**  
Health Prof Educ (2016)  
[Google Scholar](#)
- 14 D.M. Taylor, R. Wolfe, P.A. Cameron  
**Complaints from emergency department patients largely result from treatment and communication problems**  
Emerg Med, 14 (1) (2002), pp. 43-49  
[View Record in Scopus](#) [Google Scholar](#)
- 15 S. Gaal, C. Hartman, P. Giesen, C. van Weel, W. Verstappen, M. Wensing  
**Complaints against family physicians submitted to disciplinary tribunals in the Netherlands: lessons for patient safety**  
Ann Fam Med, 9 (6) (2011), pp. 522-527  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 16 G. Salazar, K. Quencer, S. Aran, H. Abujudeh  
**Patient satisfaction in radiology: qualitative analysis of written complaints generated over a 10-year period in an academic medical center**  
J Am Coll Radiol, 10 (7) (2013), pp. 513-517  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 17 S. Zengin, B. Al, E. Yavuz, *et al.*  
**Analysis of complaints lodged by patients attending a university hospital: a 4-year analysis**  
J Forensic Leg Med, 22 (2014), pp. 121-124  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 18 M.M. Wofford, J.L. Wofford, J. Bothra, S.B. Kendrick, A. Smith, P.R. Lichstein  
**Patient complaints about physician behaviors: a qualitative study**  
Acad Med, 79 (2) (2004), pp. 134-138  
[View Record in Scopus](#) [Google Scholar](#)
- 19 B. Schaad, C. Bourquin, F. Bornet, *et al.*  
**Dissatisfaction of hospital patients, Their relatives, And friends: analysis of accounts collected in a complaints center**  
Patient Educ Couns, 98 (6) (2015), pp. 771-776



- 20 M. Wessel, G. Helgesson, N. Lynoe  
**Experiencing bad treatment: qualitative study of patient complaints concerning their treatment by public health-care practitioners in the County of Stockholm**  
*Clin Ethics*, 4 (4) (2009), pp. 195-201  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 21 S. Dosanjh, J. Barnes, M. Bhandari  
**Barriers to breaking bad news among medical and surgical residents**  
*Med Educ*, 35 (3) (2001), pp. 197-205  
[View Record in Scopus](#) [Google Scholar](#)
- 22 E.A. Rider, K. Volkan, J.P. Hafler  
**Pediatric residents' perceptions of communication competencies: implications for teaching**  
*Med Teach*, 30 (7) (2008), pp. e208-e217  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 23 R. Brown, S. Dunn, K. Byrnes, R. Morris, P. Heinrich, J. Shaw  
**Doctors' stress responses and poor communication performance in simulated bad-news consultations**  
*Acad Med J Assoc Am Med Coll*, 84 (11) (2009), pp. 1595-1602  
[View Record in Scopus](#) [Google Scholar](#)
- 24 E. Jangland, L. Gunningberg, M. Carlsson  
**Patients' and relatives' complaints about encounters and communication in health care: evidence for quality improvement**  
*Patient Educ Couns*, 75 (2) (2009), pp. 199-204  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 25 M.M. Bismark, D.M. Studdert  
**Realising the research power of complaints data**  
*N Z Med J*, 123 (1314) (2010), pp. 12-17  
[View Record in Scopus](#) [Google Scholar](#)
- 26 D. Moshman  
**Exogenous, endogenous, and dialectical constructivism**  
*Dev Rev*, 2 (4) (1982), pp. 371-384  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 27 Schunkm D.H., *Constructivism. Learning Theories: And Educational Prespective.* Boston; Pearson; 2012: 228–277.

- 28 D. Wood, J.S. Bruner, G. Ross  
**The role of tutoring in problem solvin**  
J Child Psychol Psychiatry, 17 (2) (1976), pp. 89-100  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 29 B. Downe-Wamboldt  
**Content analysis: method, applications, and issues**  
Health Care Women Int, 13 (3) (1992), pp. 313-321  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 30 R.P. Weber  
Basic Content Analysis (2nd ed.), Sage Publications, California (1990)  
[Google Scholar](#)
- 31 N.K. Denzin  
Sociological Methods: A Sourcebook (2nd ed.), McGraw-Hill, New York (1978)  
[Google Scholar](#)
- 32 M.Q. Patton  
**Enhancing the quality and credibility of qualitative analysis**  
Health Serv Res, 34 (5 Pt 2) (1999), pp. 1189-1208  
[View Record in Scopus](#) [Google Scholar](#)
- 33 W. Nöth  
**Handbook of Semiotics**  
Indiana University Press, Bloomington (1995)  
[Google Scholar](#)
- 34 R.E. Petty, L.R. Fabrigar, D.T. Wegener  
**Emotional factors in attitudes and persuasion**  
R.J. Davidson, K.R. Scherer, H.H. Goldsmith (Eds.), Handbook of Affective Sciences.  
Series in Affective Science, Oxford University Press, New York (2003), pp. 752-772  
[Google Scholar](#)
- 35 D. Matsumoto, D. Keltner, M.N. Shiota, M. O'Sullivan, M. Frank  
**Facial Expressions of Emotion**  
M. Lewis, J.M. Haviland-Jones, L.F. Barrett (Eds.), Handbook of Emotions (3rd ed.),  
Guilford Press, New York (2008), pp. 211-234  
[View Record in Scopus](#) [Google Scholar](#)
- 36 M.L. Knapp, J.A. Hall, T.G. Horgan

## **Nonverbal Communication in Human Interaction**

8th ed, Cengage Learning, Boston (2013)

[Google Scholar](#)

- 37 N. Ambady, J. Koo, R. Rosenthal, C.H. Winograd  
**Physical therapists' nonverbal communication predicts geriatric patients' health outcomes**  
Psychol Aging, 17 (3) (2002), pp. 443-452  
[View Record in Scopus](#) [Google Scholar](#)
- 38 W. Sikorski  
**Paralinguistic communication in the therapeutic relationship**  
Arch Psychiatry Psychother, 14 (1) (2012), pp. 49-54  
[View Record in Scopus](#) [Google Scholar](#)
- 39 T.A. Judge, R. Ilies  
**Affect and job satisfaction: a study of their relationship at work and at home**  
J Appl Psychol, 89 (4) (2004), pp. 661-673  
[View Record in Scopus](#) [Google Scholar](#)
- 40 J. Noordman, P. Verhaak, I. van Beljouw, S. van Dulmen  
**Consulting room computers and their effect on general practitioner-patient communication**  
Fam Pract, 27 (6) (2010), pp. 644-651  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 41 A. Shachak, S. Reis  
**The impact of electronic medical records on patient-doctor communication during consultation: a narrative literature review**  
J Eval Clin Pract, 15 (4) (2009), pp. 641-649  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 42 R.S. Margalit, D. Roter, M.A. Dunevant, S. Larson, S. Reis  
**Electronic medical record use and physician-patient communication: an observational study of Israeli primary care encounters**  
Patient Educ Couns, 61 (1) (2006), pp. 134-141  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 43 A.S. O'Malley, G.R. Cohen, J.M. Grossman  
**Electronic medical records and communication with patients and other clinicians: are we talking less?**  
Issue Brief Cent Stud Health Syst Change (131) (2010)  
[1--4]

- 44 Z. Kazmi  
**Effects of exam room EHR use on doctor-patient communication: a systematic literature review**  
Inform Prim Care, 21 (1) (2013), pp. 30-39  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 45 R.G. Hagerty, P.N. Butow, P.M. Ellis, S. Dimitry, M.H.N. Tattersall  
**Communicating prognosis in cancer care: a systematic review of the literature**  
Ann Oncol, 16 (7) (2005), pp. 1005-1053  
[Article](#)  [Download PDF](#) [CrossRef](#) [View Record in Scopus](#)  
[Google Scholar](#)
- 46 L.A. Shay, J.E. Lafata  
**Where is the evidence? A systematic review of shared decision making and patient outcomes**  
Med Decis Mak, 35 (1) (2015), pp. 114-131  
[CrossRef](#) [Google Scholar](#)
- 47 M.C. Beach, D.L. Roter, N.Y. Wang, P.S. Duggan, L.A. Cooper  
**Are physicians' attitudes of respect accurately perceived by patients and associated with more positive communication behaviors?**  
Patient Educ Couns, 62 (3) (2006), pp. 347-354  
[Article](#)  [Download PDF](#) [View Record in Scopus](#) [Google Scholar](#)
- 48 K. Hallin, P. Henriksson, N. Dalén, A. Kiessling  
**Effects of interprofessional education on patient perceived quality of care**  
Med Teach, 33 (1) (2011), pp. e22-e26  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 49 D.R. Bridges, R.A. Davidson, P.S. Odegard, I.V. Maki, J. Tomkowiak  
**Interprofessional collaboration: three best practice models of interprofessional education**  
Med Educ Online, 16 (1) (2011), pp. 1-10  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)
- 50 Y. McGowan, N. Humphries, H. Burke, M. Conry, K. Morgan  
**Through doctors' eyes: a qualitative study of hospital doctor perspectives on their working conditions**  
Br J Health Psychol, 18 (4) (2013), pp. 874-891  
[CrossRef](#) [View Record in Scopus](#) [Google Scholar](#)

- 51 Hamdy H. One Size Does Not Fit All: Blended Learning Strategies in Medical Education. *Heal Prof Educ.* 2015;1(1):65-66.  
[Google Scholar](#)
- 52 Vaughn L, Baker R. Teaching in the medical setting: balancing teaching styles, learning styles and teaching methods. *Med Teach.* 2001;23(6):610-612.  
[Google Scholar](#)
- 53 Harden RM, Laidlaw JM. Be FAIR to students: four principles that lead to more effective learning. *Med Teach.* 2013;35(1):27-31.  
[Google Scholar](#)
- 54 Kaufman DM. Applying educational theory in practice. *BMJ.* 2003;326(7382).  
[Google Scholar](#)
- 55 Hodges BD, Kuper A. Theory and Practice in the Design and Conduct of Graduate Medical Education. *Acad Med.* 2012;87(1):25-33.  
[Google Scholar](#)

**Dr. Janine W.Y. Kee**, MBBS, MRCPsych, is an Associate Consultant Psychiatrist at Tan Tock Seng Hospital and a Core Clinical Faculty Member for the National Healthcare Group Transitional Year Residency Program. She is also an Adjunct Faculty of the National Healthcare Group College and a Clinical Teacher at the Lee Kong Chian School of Medicine.

**Dr. Khoo Hwee Sing**, B.B.A., M.Comm., Ph.D. (Management), is a Research Analyst at the Health Outcomes and Medical Education Research unit (HOMER), Education Development Office of the National Healthcare Group.

**Mr. Issac Lim**, B.B.A. (Hons), M.Sc. (Management), M.A. (Sociology), M.S. (Management Science & Engineering), heads the Health Outcomes and Medical Education Research unit (HOMER), Education Development Office of the National Healthcare Group.

**Dr. Mervyn Y.H. Koh**, MBBS, MRCP, FAMS, is a Senior Consultant and heads the Department of Palliative Medicine at Tan Tock Seng Hospital. He is also Associate Professor, Lead for Palliative Medicine and Clinical Practice Facilitator at Lee Kong Chian School of Medicine.

Peer review under responsibility of AMEEMR: the Association for Medical Education in the Eastern Mediterranean Region

© 2017 King Saud bin Abdulaziz University for Health Sciences. Production and hosting by





[About ScienceDirect](#)

[Remote access](#)

[Shopping cart](#)

[Advertise](#)

[Contact and support](#)

[Terms and conditions](#)

[Privacy policy](#)

We use cookies to help provide and enhance our service and tailor content and ads. By continuing you agree to the **use of cookies**.

Copyright © 2021 Elsevier B.V. or its licensors or contributors. ScienceDirect® is a registered trademark of Elsevier B.V.

ScienceDirect® is a registered trademark of Elsevier B.V.

