General Medical Council

Reducing harms and improving communication

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Working with doctors Working for patients

Context: Our Strategy

Supporting doctors in maintaining good practice

Strengthening collaboration with our regulatory partners across the health services

Strengthening our relationship with the public and the profession

Meeting the changing needs of the health services across the four countries of the UK.

Identifying and understanding risk to support doctors practice: reducing harms

Identifying, understanding and where feasible, acting upon critical problems which present harm to patients and doctors.

Harm may stem from multiple problems at three different levels.

Individual	Unsafe and / or unethical medical practice
System	Insufficient support for safe and ethical practice
Regulator	Insufficient facilitation , collaboration and guidance for safe and ethical practice

Reducing harms programme – 3 aims

1. To learn

2. To share

3. Where appropriate, to act…collaboratively

Communication failings: A multi-faceted problem…

.....that can and does lead to patient harm

- **Approx one third GMC investigations** during 2010-2014, following complaints from public, involved poor communication and respect

- **28% of all written complaints** submitted to Health Boards in 2015/16 related to the category of communication, staff attitude and staff competence

- **A recurring theme in reviews and inquiries:** Vale of Leven Inquiry and the (invited) review of NHS Grampian's general surgery service both pointed to communication difficulties

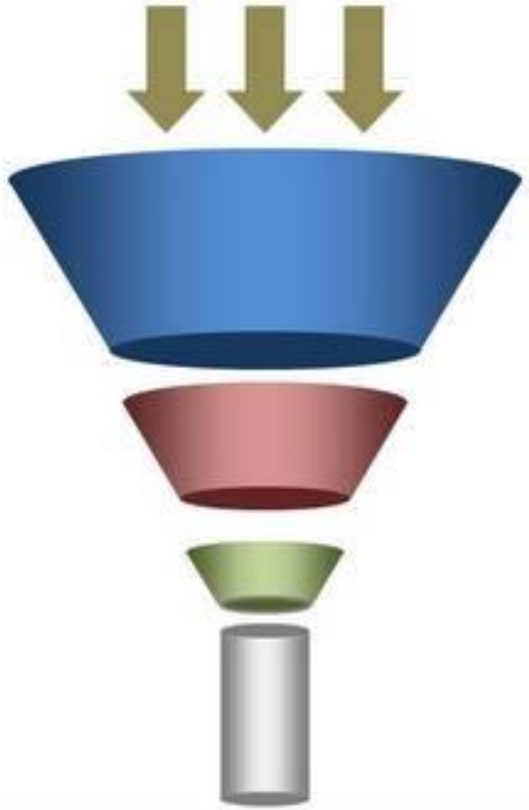
- **A leading cause of avoidable surgical errors** is poor communication between hospital support staff and surgeons

Tackling this in more detail – a pilot 'harms' study

1. Develop taxonomy of communication failings

2. In-depth analysis of 3 - 4 'types' using existing complaint data

3. Consideration of outcomes, co-production where possible.



Early views on poor communication – initial engagement exercise

GP complaints	Hospital complaints
Communication during consultation	
	Consent and communication
	Communication on discharge
Difficult conversations around prognosis & EOLC	
Patients & relatives not feeling listened to	
Doctors not feeling listened to by colleagues	
Misunderstandings & lack of clarity	
Lack of ownership or responsibility for communication	
	Not being kept informed or updated
Medical records & referral letters	
Rude, arrogant & dismissive attitudes	
Organisational or system issues	

Stage 1: Exploring this further through a commissioned review of published literature

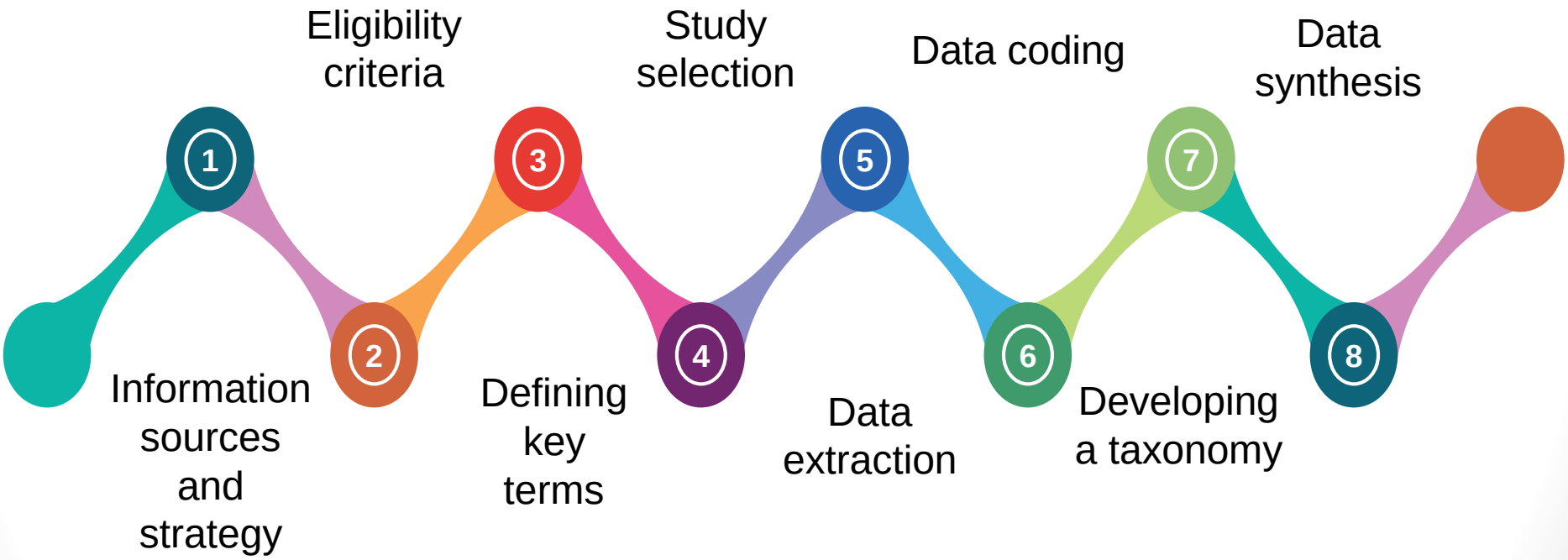
01 What are the most commonly reported / studied types of communication failure that lead to substandard care or patient harm?

02 What parts of the care process do the communication failures correspond to and which professional groups do they affect/involve?

03 What evidence is there on the contributory factors that lead to communication failure, and is there consensus or a shared view on the main factors?

Overview of methods

Steps involved in conducting the review

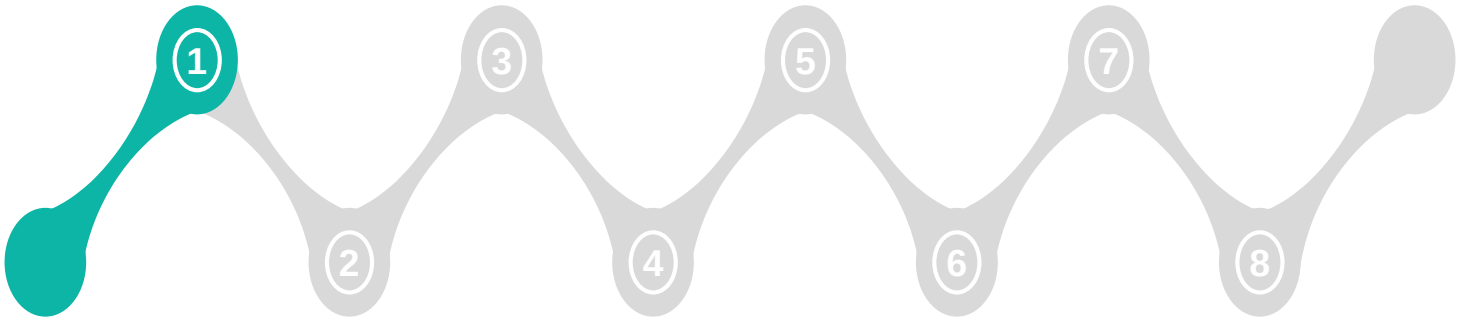


Information sources and strategy

01

Stepwise approach

Iterative discussion with project team
Electronic searching of 17 databases and grey literature to find relevant studies



Selection criteria

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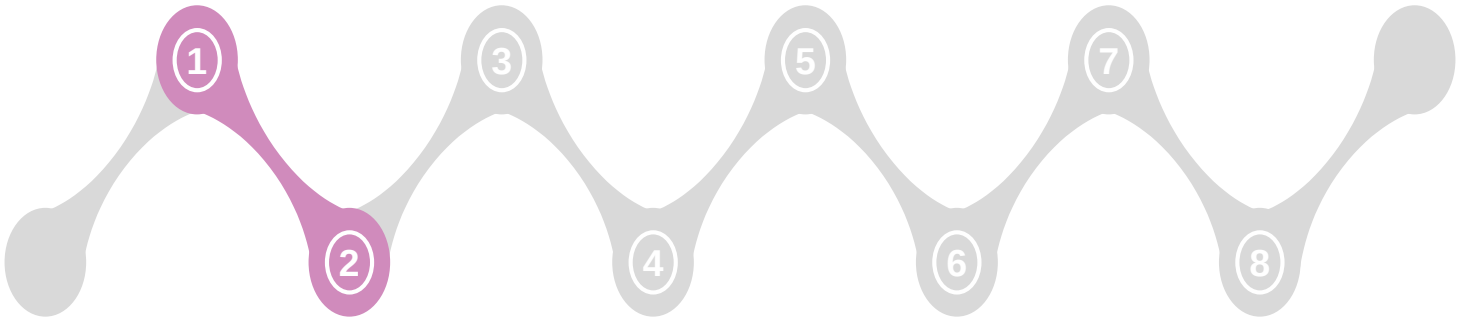
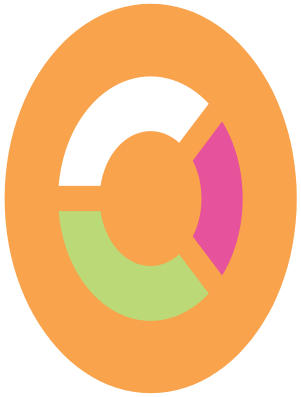
Eligibility criteria

1. Published in English between 2010 and Nov 2017
2. Wide range of study designs were included
3. Studies with a focus on communication problems within medicine (not other HCP) and studies with a focus on ‘interpersonal’ communication were included



Defining key terms



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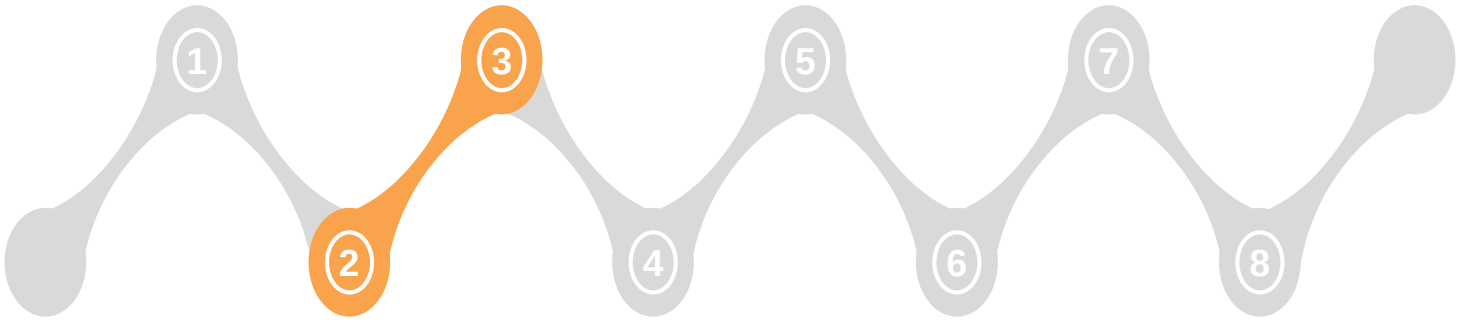
Agree operational definitions

Defining communication, communication failure, contributing factors, patient harm, substandard care, taxonomy



Study selection

04

Selecting studies for inclusion

One reviewer ran the search strategy, and removed any obviously irrelevant titles. Two reviewers independently reviewed abstracts and assessed full text papers for inclusion

Data extraction

05

Two reviewers extracted the following information:

1. Study characteristics (e.g. aims, design, method)
2. Method and mode of communication
3. Contextual factors (e.g. setting, stage of healthcare)
4. Professional groups involved
5. Communication error
6. Contributory factors

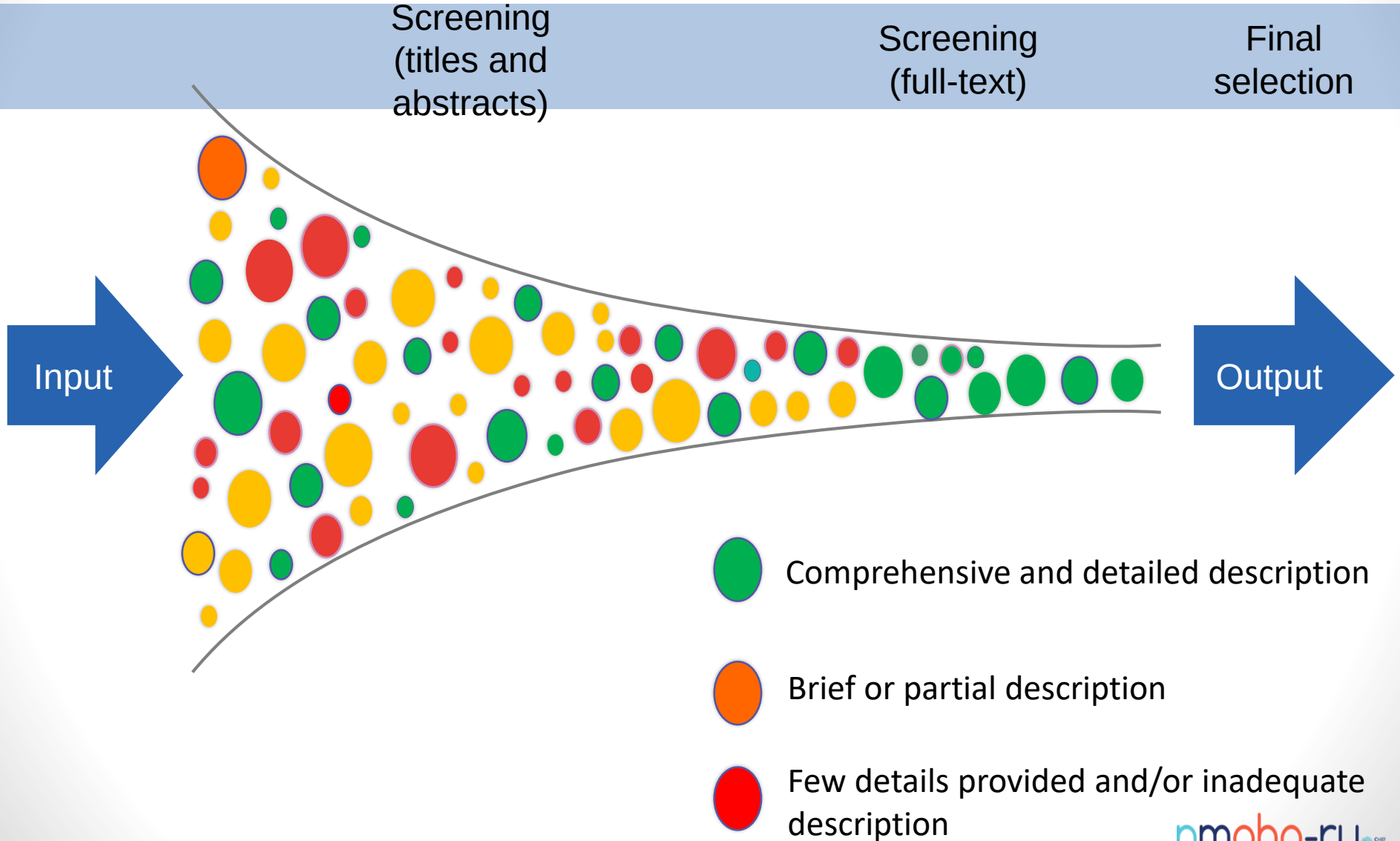
Coding the data

06

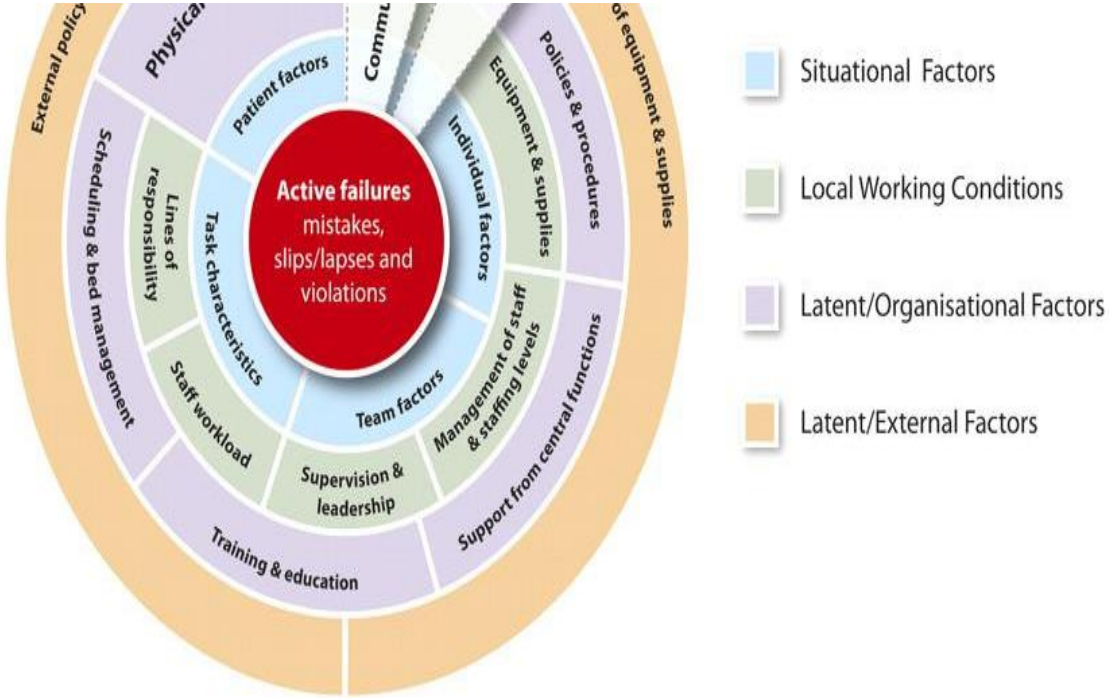
The following data was coded:

1. Comprehensiveness of the description of the communication failure
2. Relevance of study to the UK setting
3. Communication error
4. Patient harm
5. Contributing factors

Comprehensiveness



Deductive coding: Contributory factors based on modified Lawton (2012) contributory factors framework



Factor	Definition
Active failures	Any failure in performance or behaviour (eg, error, mistake, violation) of the person at the 'sharp-end' (the hea professional)
Communication systems	Effectiveness of the processes and systems in place for the exchange and sharing of information between sta groups, departments and services. This includes both written (eg, documentation) and verbal (eg, handover) communication systems

Developing a taxonomy

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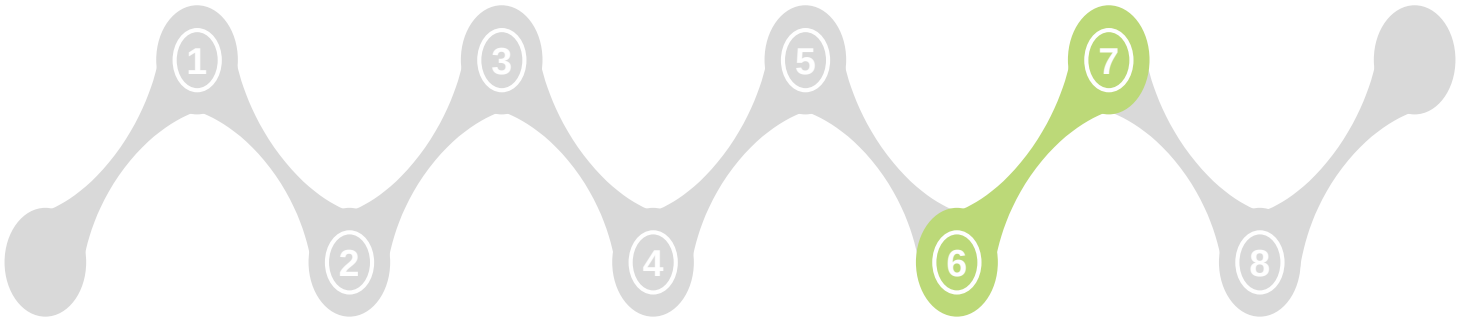
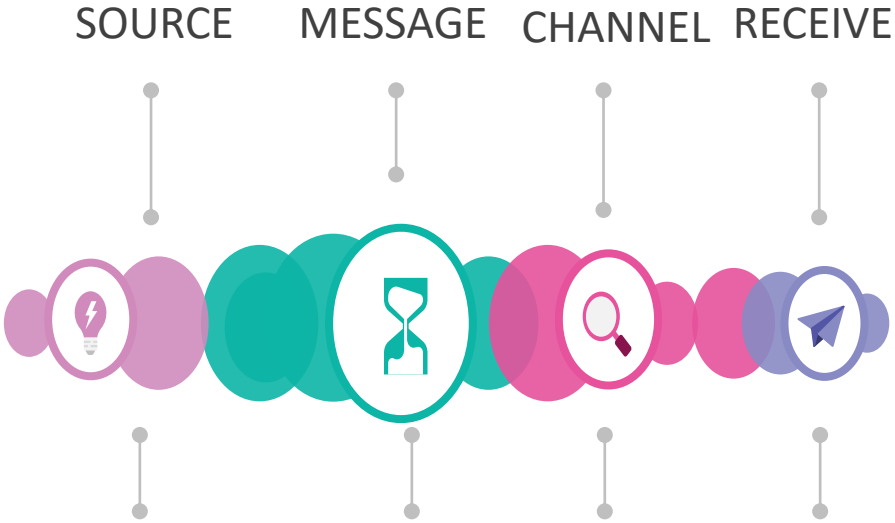
Building a taxonomy

Independently agreed and pre-selected 70 codes from the GMC Fitness to Practice Allegations Handbook based on the definitions
Inductive coding was then used to develop a further 15 codes from the ‘other’ codes.



Berlo's Model of Communication

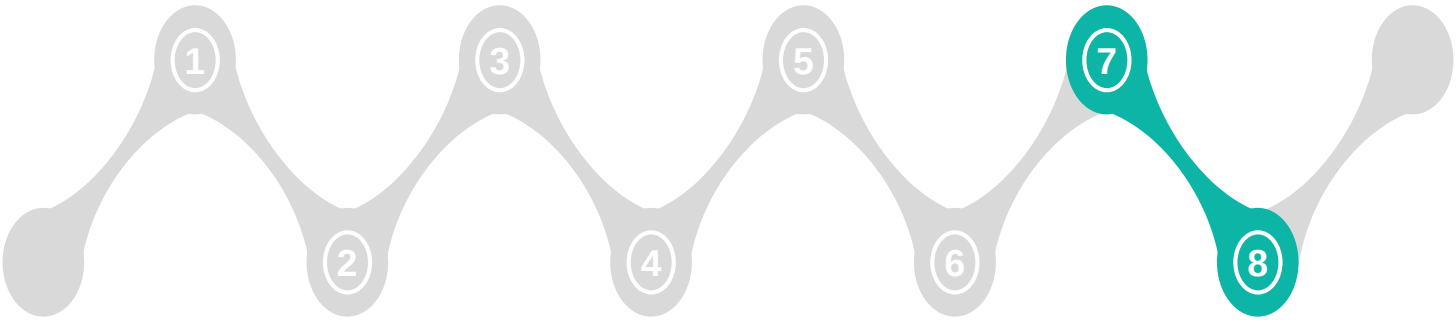


SOURCE	MESSAGE	CHANNEL	RECEIVER
Comm. skills	Content	Hear	Comm. skills
Attitude	Elements	See	Attitude
Knowledge	Treatment	Touch	Knowledge
Social system	Structure	Smell	Social system
Culture	Code	Taste	Culture

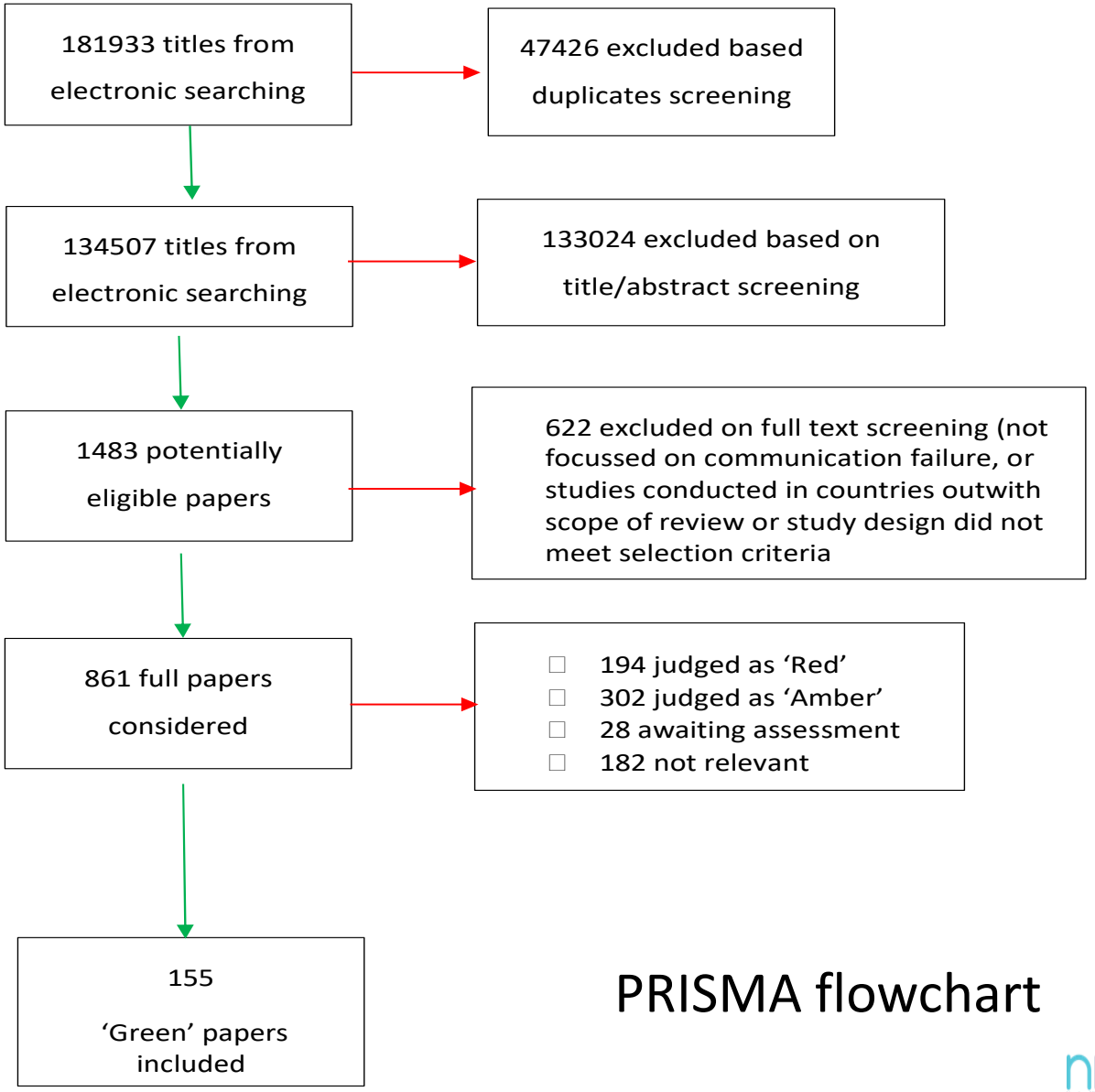
Data synthesis

08 Final synthesis

1. Evidence tables
2. Heat maps
3. Series of vignettes



Findings



PRISMA flowchart

Main communication failures

01

Failure to provide the patient with appropriate and timely information

Reported in 66 studies; mapped to effective communication domain

02

Failure to keep colleagues informed or share appropriate level of information

Reported in 45 studies: mapped to effective communication domain

03

Failure to listen to patients

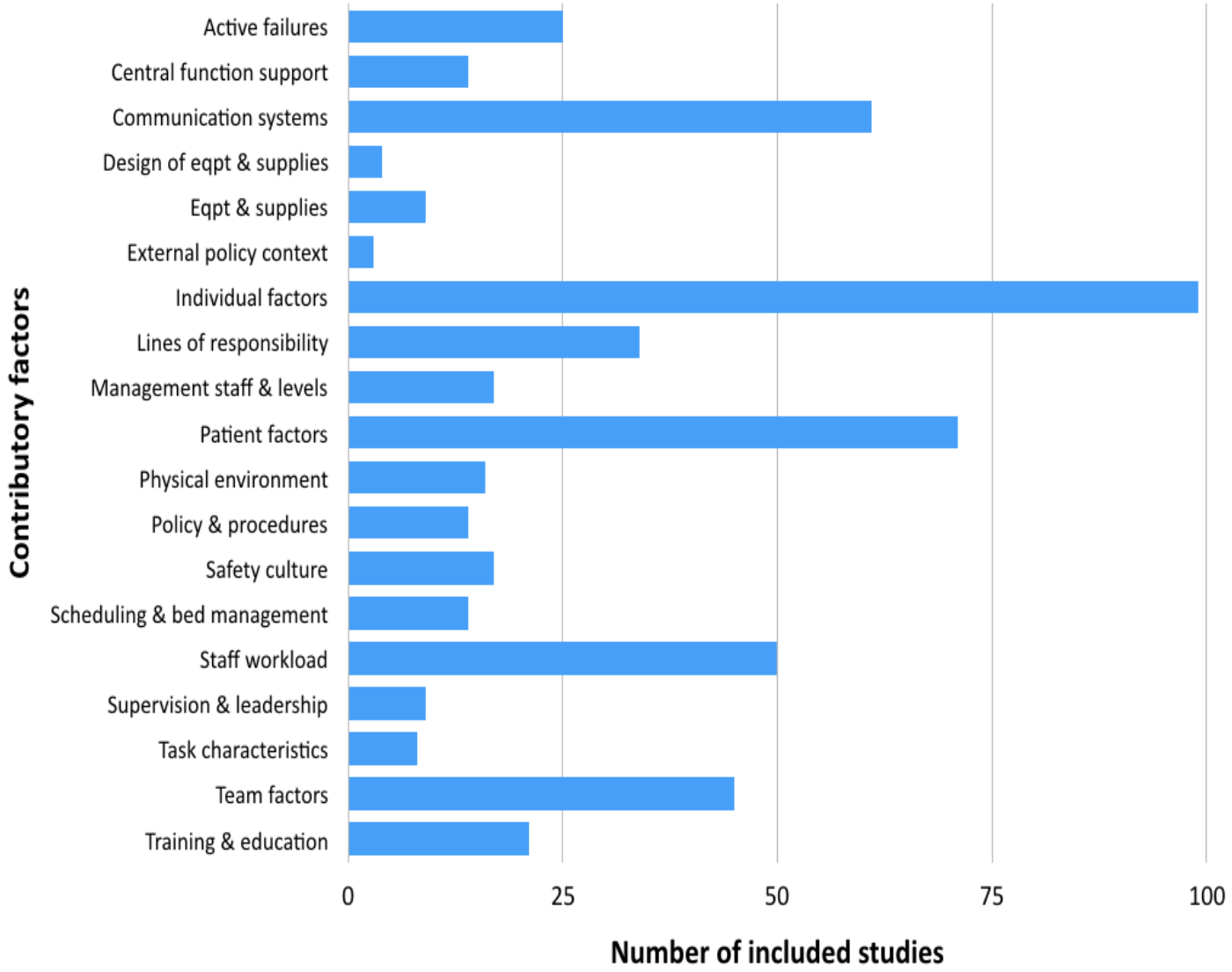
Reported in 31 studies; mapped to effective communication domain

04

Failure to work in partnership or collaboratively with patients, family or carers

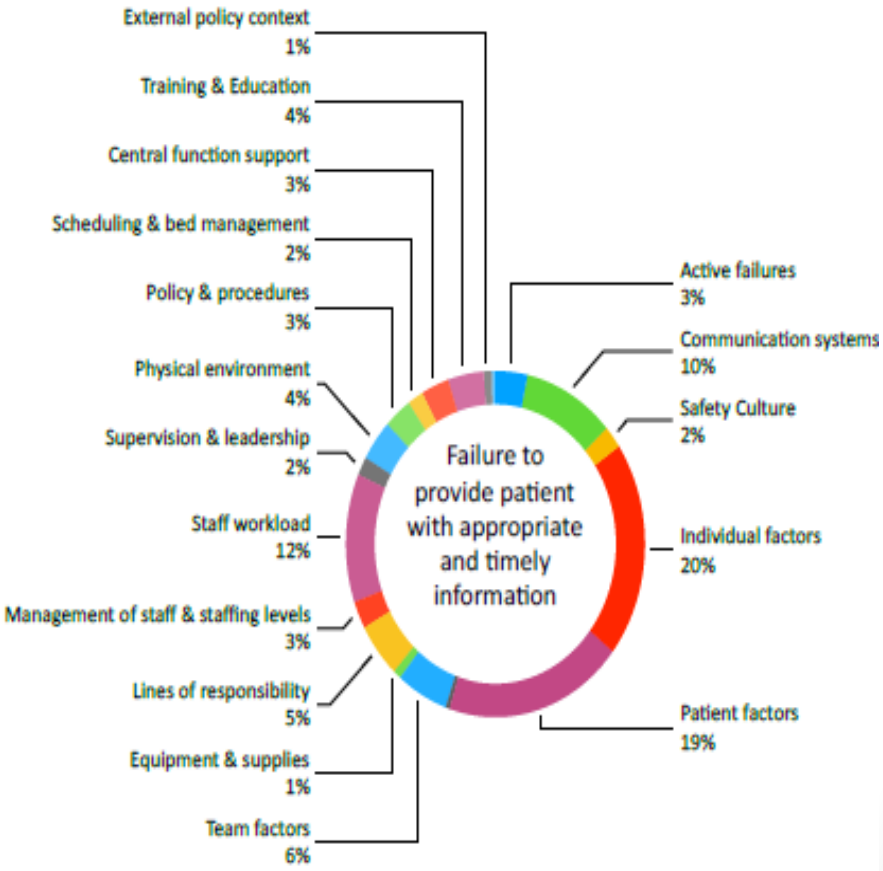
Reported in 38 studies: mapped to attitude, teamwork and collaboration domain

Contributory factors reported across studies

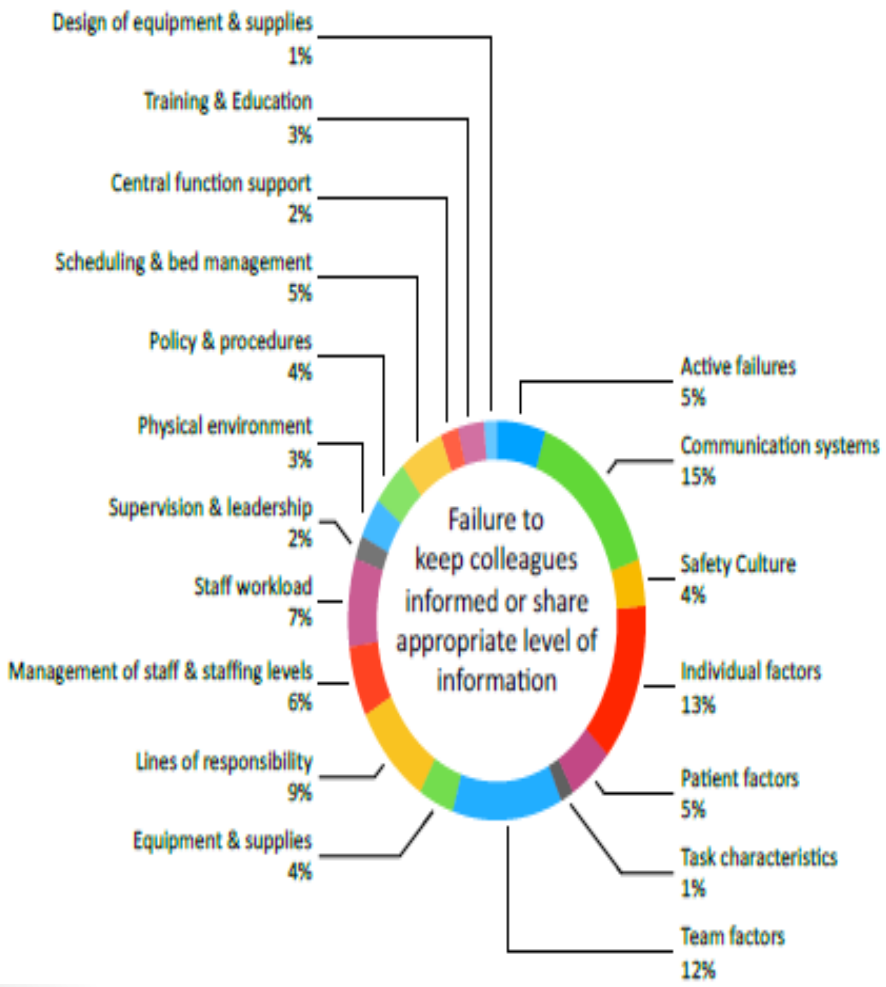


Failure to provide appropriate and timely information

"I spoke to the house doctor, I can't remember her name. She said did I realise that my mother was dying through the effects of the infection from C. diff and I at that point I wasn't aware my mother was dying, I thought they were trying to make her better, and that's why she was in the isolation room." [Family member]



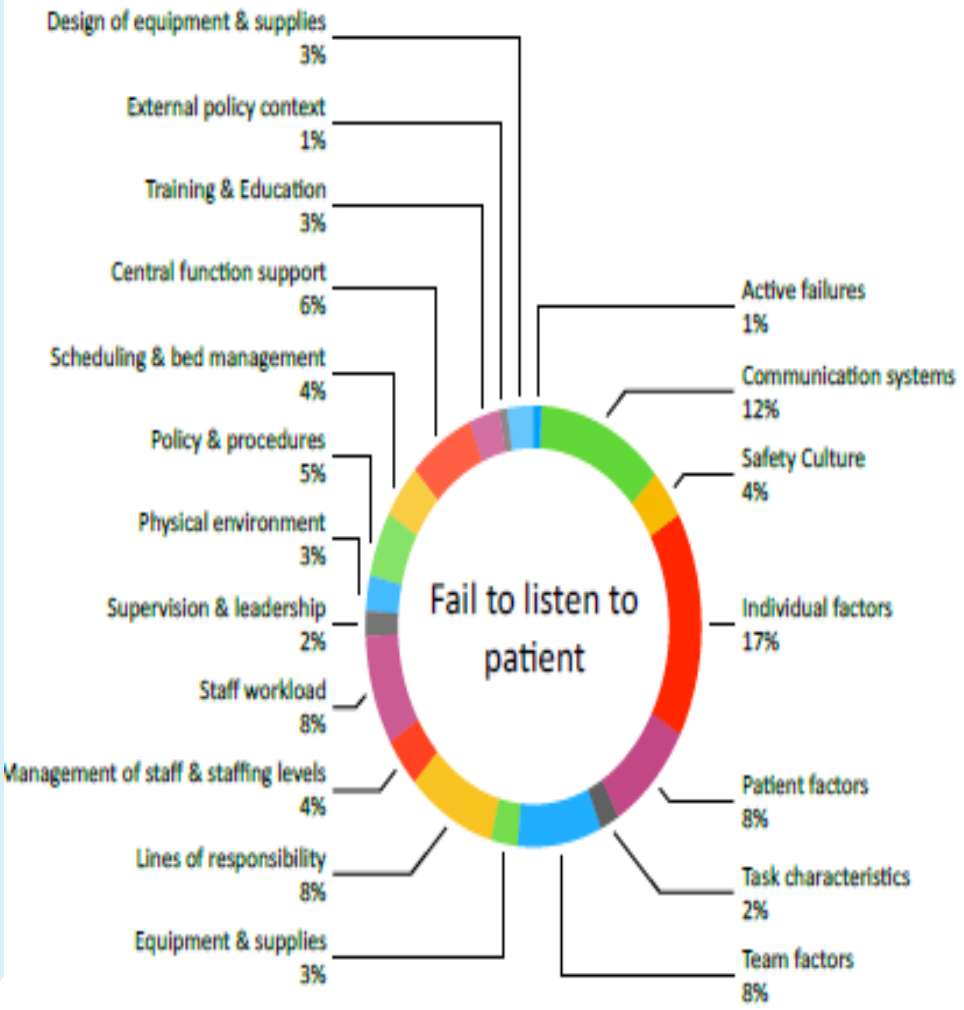
Failure to keep colleagues informed or share appropriate level of information



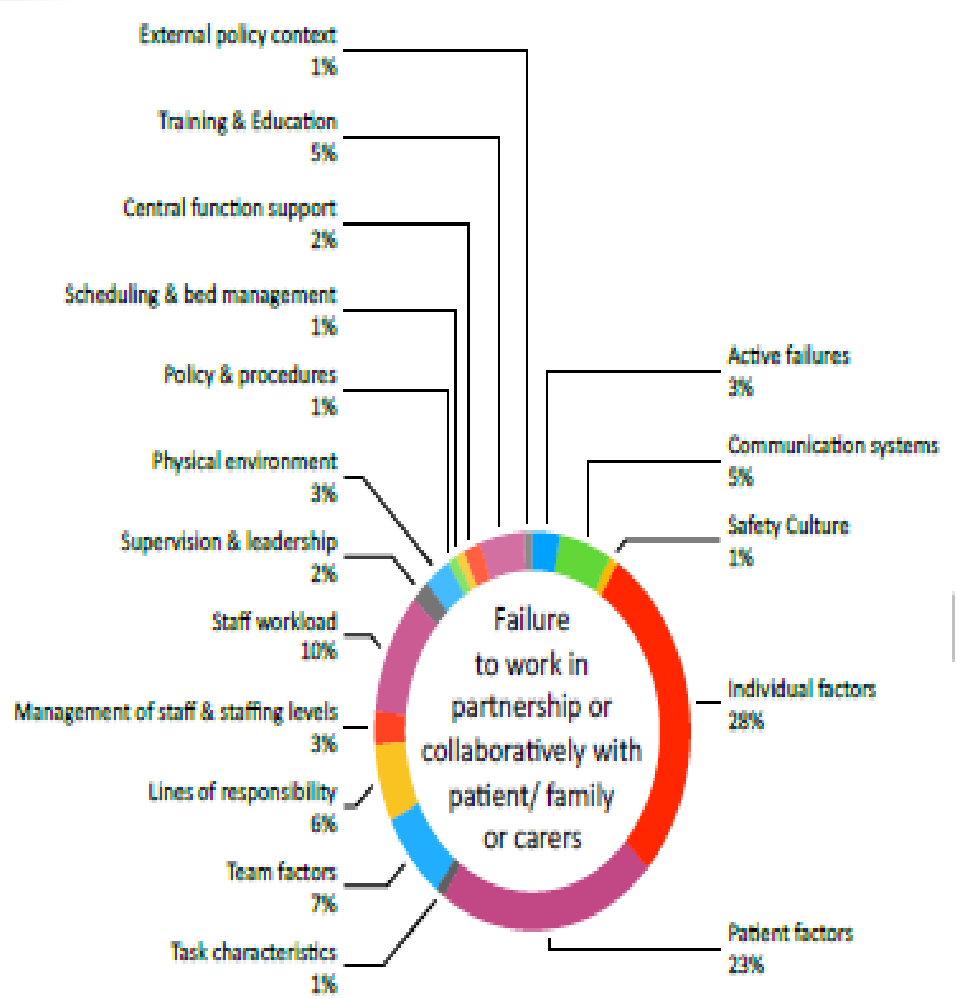
"All hell broke loose when Mr [XXX, the surgeon] found out the patient's antibiotics hadn't been started. His yelling, 'Can someone explain to me why Mr [XXX] hasn't received his antibiotics? I specifically asked for them.' Everyone was quiet; no one was talking, as there was no good reason.
I just missed it. It wasn't handed over. [DPU_nur_98_Observation] (p 1879)."

Failure to listen to patients

"Physician: [If] a 25 year old comes in, with your condition, the same CML in stable phase and has a sibling that matches, you know, I'll probably decide on doing a bone marrow transplant. Knowing there is a risk of this transplant, but if you do well with the transplant, it's a good chance that you're cured. However, for people who are older and who have medical conditions, you know, for example, in your case the colon cancer and other issues, um, those kind of transplants might be a bit too risky. ……. So what's the alternative to transplantation, is the next question. So, in the past, there hadn't been any very good treatments for this disease. People have used a drug called Hydrea to control the counts, Hydroxyurea, it's a pill you take once a day. That controls your white blood cell counts but it does not delay the progression of the disease and does not change survival. The only drug in the past that has impacted on survival is a drug called interferon. . . . The problem with interferon is that it is a terrible drug. People get very depressed on it, people get lots of flu like symptoms, so, you know, based on what you are telling me now, I think interferon would be a very bad drug for you, just because of the depression issues, the fibromyalgia issues…… Well the exciting thing is then, there's this drug called Gleevec. It's obviously a recent development. Gleevec has been approved only a couple of years ago, 3 or 4 years ago. And the way Gleevec works, is that, Gleevec is actually the first drug, what we call a rationally designed drug. . . . As I told you, this disease, it's the hallmark of the disease, is this translocation, where you have this break between chromosome 9 and chromosome 22. It makes this new Gene called the BCR-ABL gene. Well, since we've been able to clone this gene, they actually make this thing in the laboratory, you can actually test things that can block it. Well one of the researchers . . . was interested in seeing if he could find chemicals that specifically block this gene. . . . And after going through an exhaustive search, they've isolate one, in particular, that seems to be very effective in blocking the action of this gene. . . . And so, you know, basically, it's very basically a design drug. [71](p574)



Failure to work in partnership or collaboratively with patient, family or carers



"Physician: Anything else you guys were hoping we would do today? Patient: I declined the Heparin- I didn't feel like I really wanted to take it. Physician: The shot? Patient: Yea. Do you think that would really be helpful at this point? Physician: Yea, because we give for everybody here the [Heparin] shot, unless you get up every 2 hours and walk around.

Patient: I'm doing that pretty much, I'm going to the bathroom. How far do you want me to walk? It's a blood thinner.

Physician: The cholesterol looks fine, no need to worry, if anything is up then maybe I will give you an extra medicine when you go home. Patient: But how much is it up? Physician: I'm going to check on that, I don't know the answer yet.

Patient: Because my cholesterol has generally been a little high, but pretty, pretty good. Physician: Good? Patient: Good, yea. Physician: So only when it is high, I'll give you, otherwise I won't give you any extra medicine.

Patient: I would rather. Frankly, I don't want to take medications unless I really have to. Physician: Really, you have to do" (Table 4, p1478)

Limitations

- Rapid scoping review so unlikely that we have identified all of the relevant examples of communication error
- Papers were coded based on comprehensiveness
- No formal evaluation of the taxonomy
- Focus on frequency of reporting so does not consider issues relating to:
  - severity of the communication failure,
  - actual numbers of communication failures as found within a study or clinical setting,
  - methodological design or
  - quality of the study contributing data

Stage 1: Drilling down into the detail – professional and patient contributory factors….

- Story telling & health literacy
- Contrasting belief systems and limited tailoring of message
- Misplaced assumptions (& patient involvement)
- Transmitting information but not communicating
- Non-verbal cues not recognised or employed
- Questioning perceived as challenge

Stage 1: Drilling down into the detail – professional and patient contributory factors (2)

- Managing the expectations gap – acceptance vs returning to normal
- Contested professional boundaries
- And underpinning all of this….communication tensions:
  - Efficiency vs rapport
  - Efficiency vs comprehension
  - Professional vs patient approach to clarity and relevance

Stage 2 next steps: Drilling down into individual GMC complaints

Focusing on four types of FtP allegation:

- Dr fails to give colleagues appropriate information
- Dr fails to listen to patients
- Dr fails to work in partnership with patients/carers/family (ie. shared decision making with non Medics)
- Dr fails to meet communication need

Focusing on 5-6 cases per question focusing on four grouped specialties:

- General Practice
- Medicine
- Surgery
- Obstetrics & gynaecology

Moving to stage 3: addressing the problem – where are the potholes and how do we fill?

Stage 3 - What provision currently available in this area

Non-technical skills for surgeons	Mastering professional interactions	Consent guidance	EOLC guidance & training
Difficult conversations training	Duty of Candour guidance & training	General comms guidance & training	Shared decision making training
Achieving safer and reliable practice	Communicating risk & clinical communication	Effective communication for healthcare training	Health literacy tools and training

And finally…questions for us and questions for you…

- To what extent does this chime with your experiences of inadequate communication?
- Is guidance and training always the answer - are there other examples of good practice – perhaps locally adopted – that could be shared further?
- Any other questions?

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