“I consider communication to be a very important part of my work in the consulting room”
(social insurance physician, female, working as a social insurance physician for 15 years)

“Our profession actually has more to do with social contact; it’s not about being formal. We try to communicate in such a way that people feel at ease when they tell their story.”
(social insurance physician, male, working as a social insurance physician for 9 years)

“The physician left me in uncertainty about his conclusions. Later on, that made me worried.”
(work disability claimant, female, 35 years)

“The interview was very positive. I did not like the idea of it, but I was reassured and everything was clarified satisfactorily! When the emotions ran high, the physician asked if I needed a break.”
(work disability claimant, female, 49 years)

These quotations illustrate, both from the perspective of the physician and from that of the medical disability claimant, that there are many reasons why communication of physicians is important in performing work disability assessment interviews. Also from other perspectives its importance seems obvious. Yet, scientific research has paid hardly any attention to it.

Focus of this thesis
This thesis focuses on communication in face-to-face encounters between social insurance physicians and work disability claimants during assessment interviews for disability benefits. Special attention is paid to the development and evaluation of a communication skills training course for social insurance physicians. This first chapter will present the main definitions used in this thesis. In addition, an explanation is given of the importance of communication in physician-patient encounters in general, and in work disability assessment interviews in particular. At the end of this chapter, the objectives and outline of this thesis are presented.

Main definitions in this thesis
According to the MeSH Dictionary [1] ‘communication’ is a subcategory of behaviour. In this thesis, we have defined communication in accordance with the MeSH Dictionary
as verbal and nonverbal exchange and transmission of information between the social insurance physician and the disability claimant during a face-to-face encounter. This exchange of information is a continuous, dynamic, two-directional process. The information may include facts, ideas, opinions, attitudes, beliefs, emotions, and feelings. The exchange of information may be both conscious and unconscious.

It is difficult to define when communication is adequate and when it is inadequate. Moreover, definitions change over time. In this thesis, communication is considered to be adequate when it is two-directional and the transferred information is likely to be understood as it was intended, resulting in a mutual understanding. Adequate communication includes that the expectations of both the physician and the claimant (e.g. expectations with regard to the roles of both people) are either met or if they are not met, this lack of meeting expectations is explicitly addressed. Also, adequate communication meets both the cognitive and the emotional needs of the claimants, in an evenly balanced way. In general, cognitive needs ask for instrumental communication by the physician (e.g. information, advice) and emotional needs ask for affective communication (e.g. empathy, emotional support) [2-4].

Other terms that are used regularly to indicate communication between people are ‘interaction’ and ‘interpersonal interaction’. Interaction is less well defined in, for example, the MeSH Dictionary and seems to be used less in scientific writing than communication. Therefore, we have chosen to use communication in this thesis instead of interaction, even though – at least in the Dutch language – both terms have a comparable, largely overlapping meaning.

Relevance of this thesis
In everyday life adequate and effective communication is of great importance. This importance extends to working life [5], especially when jobs are concerned in which the professional is supposed to help, guide, or advise other people (e.g. psychologist, physician). In these professions, adequate communication skills are essential for delivering good care [6-8]. Therefore, it is not surprising that there exist numerous guidelines [9] and approaches in communication skills training for professionals [8,10].

Why is communication in physician-patient consultations important?
In scientific research, it was found that the quality of care of physicians and the degree of effective communication are related. For example, a higher quality of care positively influences the information exchange and leads to a higher satisfaction of patients with the encounter [9,11]. Furthermore, physicians who have adequate communication skills tend to identify problems of patients more accurately [12]. The importance of adequate communication is also stressed by other research findings. It was found that patients often do not understand what physicians tell them about their diagnosis and
treatment [13]. Also, more complaints and malpractice claims are filed against physicians who communicate worse [14,15]. The other way around, physicians who have no history of malpractice claims communicate better. For example, they spent more time explaining the content of the encounter and making sure the patient understood what was talked about [16].

The previous examples are from curative care, but also research findings from other areas of medicine, such as occupational medicine, stress the importance of adequate communication. Studies have indicated that adequate physician communication may increase the likelihood of return-to-work [17,18]. Also, it was found that workers, occupational physicians, insurers, and other stakeholders involved in return-to-work, experience ineffective communication as a barrier for return-to-work [19]. Moreover, communication skills are believed to be an important competency of return-to-work coordinators [20].

Adequate communication skills are not only important from a patient perspective – because of better advice, better care, and a more pleasant encounter – but also from a physician perspective. Physicians with adequate communication skills were found to have less work stress and greater job satisfaction [12]. Therefore, not only patients or claimants, but also physicians themselves, may benefit from adequate communication.

Why is communication in social insurance medicine important?
There are many similarities, but also several pronounced differences between the physician-patient relationship in curative medicine and the physician-claimant relationship in social insurance medicine. Most importantly, contrary to other physicians, social insurance physicians have to assess the functional capacity and ability to work of claimants, who have claimed for a disability benefit. A major part of this assessment is the assessment interview. In this interview, communication is the main method of information gathering. Therefore, communication can be considered a core competence in the profession of social insurance physicians. Moreover, performing a proper assessment means that social insurance physicians have to ask the right questions in an adequate way, in order to get the right information and to reach a legally fair conclusion. When all this information is gathered, the physician’s task turns into giving information, by telling the claimant the conclusions from the interview. This ‘switch’ is more pronounced than in other physician-patient consultations. Especially when the conclusions do not meet the claimant’s wishes or expectations, this is a difficult task. Therefore, social insurance physicians, apart from the medical skills, have to have adequate listening skills and skills in reassuring claimants in order that claimants provide them with the necessary information, and simultaneously have adequate skills in bringing (bad) news.

For the claimant, a disability benefit is at stake. Also, an important aspect of the claimant’s life – work and the ability to perform it or not – is discussed. Therefore,
emotions can run high. The physician should be emphatic and should be able to make
time for these emotions, also when the claimant does not show these overtly. However,
social insurance physicians generally work under time-restrictions and may only meet
the claimant once, which can make this challenging. In addition, the physicians and
the claimant have no free choice about whether they want to do the interview with the
other person or not. They are dependent on each other, and whether or not they like
each other initially, will influence the communication.

Objectives and outline of this thesis
In view of the above, it is not surprising that both claimants and physicians consider
communication in medical disability assessments important [21,22]. It is essential that
communication is addressed in research. Moreover, the results of such research
should become available to social insurance physicians in practice. In line with that,
this thesis had two main objectives:
I To explore the determinants of behaviour of both social insurance physicians and
work disability claimants with regard to their communication during assessment
interviews for disability benefits.
II To develop (using the results of the first objective and additional information) and
evaluate a post-graduate communication skills training course for social insurance
physicians.

Chapter 2 presents the theoretical framework that was the starting point in designing
the studies described in chapters 3-5. This framework is a conceptualisation of a
model for the communication behaviour of social insurance physicians and their
claimants, in face-to-face encounters during work disability assessment interviews and
the preparation thereof. It was based on the Theory of Planned Behaviour (TPB) and
the Attitude/Social influence/Self-efficacy model. In chapter 3, the determinants of
communication behaviour of social insurance physicians are addressed. These
determinants are attitudes, social influence, self-efficacy, skills, barriers, and intentions
concerning their communication with claimants in assessment interviews. The aim of
chapter 3 was to understand these determinants, by modelling them starting from the
TPB. In the study described in chapter 4, we firstly aimed to determine which types of
disability claimants can be distinguished, based on the determinants of their
communication behaviour. Secondly, we investigated their opinions about
communication, with the aim to determine if the types of claimants differed in their
perception of communication behaviour and their satisfaction with the communication
with social insurance physicians. Chapter 5 brings together the perspectives of social
insurance physicians and claimants by studying their agreements and differences of
opinion about the same assessment interviews. The study described in this chapter
aimed to gain insight into the differences between expectations of claimants about the
communication before an assessment interview and their opinions after that interview. Furthermore, this study aimed to gain insight into the differences between these opinions of claimants and the estimated claimant opinion by the social insurance physician who performed the assessment interview. In chapter 6, the results of a systematic review of literature concerning strategies for teaching qualified physicians communication skills are presented. The aim of this review was to identify effective training strategies. Chapter 7 discusses a focus group study. The aim of this study was to investigate: (1) the content of stereotypes used to classify claimants with regard to the way in which they communicate during assessment interviews; (2) the origins of such stereotypes; (3) the advantages and disadvantages of stereotyping in assessment interviews; and (4) how social insurance physicians minimise the undesirable influences of negative stereotyping. In chapter 8 the results of chapters 3-7 are combined and integrated. The aim of the study presented in this chapter was to systematically develop a training course aimed at adequate communication of social insurance physicians during work disability assessment interviews with claimants, and to plan an evaluation of that training course. Chapter 9 describes the results of the evaluation of this post-graduate training course in a randomised controlled trial. The main aims of this study were to assess whether the training course would increase competence and knowledge with regard to communication, and whether it would change the determinants of physicians’ communication behaviour. Additionally, we evaluated the opinions about the training course of the participating social insurance physicians. Finally, in chapter 10, the results of all chapters are critically discussed and put into perspective, followed by implications for practice and directions for further research.

References


