Chapter 10

General discussion and conclusions
The main focus of this thesis was the development and the evaluation of the communication skills training course ‘Professional Claimant Communication’ for social insurance physicians performing work disability assessments. In this final chapter, some of the issues that have been raised in the foregoing chapters will be linked to each other and some new subjects of discussion will be addressed. This chapter starts with an overview of the main findings of this thesis. Next, methodological considerations are addressed, and future research directions are discussed. Also, the implications for social insurance physicians and the relevance for physicians in general is addressed. The chapter ends with the main conclusions for each of the objectives of this thesis.

Main findings

The first objective of this thesis was to explore the determinants of the communication behaviour of social insurance physicians during assessment interviews for disability benefits, as well as those of work disability claimants.

- A study of the literature (chapter 2) showed that the Theory of Planned Behaviour (TPB) was a good starting point for the conceptualisation of a behavioural model for the study, for both social insurance physicians and claimants.
- A questionnaire study among social insurance physicians gave empirical support for the conceptualisation of the physician’s preparation of the interview (chapter 3). The study showed that intentions of social insurance physicians, especially intentions to give information and to consider personal aspects, could be explained by a combination of determinants of behaviour. The main determinants of these intentions were attitudes, self-efficacy, and barriers with regard to the communication with claimants.
- A questionnaire study among disability claimants gave insight into the usefulness of the conceptualisation of the preparation of claimants (chapter 4). It showed that three types of claimants could be distinguished: insecure support-seeking claimants, confident claimants, and socially isolated claimants. Especially the levels of self-efficacy, skills, social support, and intentions with regard to the communication seemed to distinguish these claimant types from each other.
- The same questionnaire study (chapter 4) showed that the three earlier mentioned types of claimants perceived the communication with the social insurance physician differently. Insecure support-seeking claimants were satisfied with the communication and confident claimants were highly satisfied, but socially isolated claimants were unsatisfied.
- A comparison of the expectations of claimants during their preparation before the assessment interview and their opinions afterward (chapter 5) showed that claimants – despite somewhat negative expectations – were rather satisfied with the communication after the interview. In addition, we found that social insurance
physicians were fairly able to accurately assess the opinion of claimants about the communication. Nevertheless, they tended to overestimate the opinions of the claimants, who were less positive than the physicians thought.

- Focus group meetings with social insurance physicians (chapter 6) gave more insight into claimants’ communication behaviour during the assessment interview as perceived by social insurance physicians. We found that during the assessment interview, the most important determinants of the communication behaviour of claimants, as perceived by social insurance physicians, were the degree of respect that claimants show in the physician-claimant relationship and claimants’ dominance in the communication.

The second objective of this thesis was to develop a post-graduate communication skills training course for social insurance physicians and to evaluate this training course. For this, the findings of the first objective were used, as well as additional information.

- To get more insight into the best training strategy we performed a review of systematic reviews (chapter 7), which showed that training courses for physicians should include active, practice-oriented strategies. Oral presentations about communication skills, modelling, and written information should only be used as supportive strategies.

- All findings were combined using the Intervention Mapping protocol as a guide (chapter 8). This resulted in a communication skills training course, of which the feasibility and practical relevance seem promising.

- The evaluation of the training course for social insurance physicians (chapter 9) showed that it may improve some aspects of their communication with claimants, but not all. Competence with regard to the introductory phase of the interview, knowledge, self-efficacy, intentions, self-reported skills, and self-reported knowledge concerning communication in work disability assessments improved. The social insurance physicians who participated in the course were unanimously very positive about it.

Methodological and practical considerations

Several methodological and practical considerations were discussed in the foregoing chapters. Below, some additional considerations are addressed.

Considerations regarding the exploration of communication behaviour

Was the TPB the right starting point?

No theoretical model for understanding social insurance physician-claimant communication was available before, as far as we know. In chapter 2 we explained why a behavioural model, more specifically an adjusted version of the TPB, would be
appropriate and useful to apply to the communication between social insurance physicians and disability claimants. Also, the Social-Cognitive Theory turned out to provide a helpful behavioural theory-based method in the development of the intervention (chapter 8). An important consequence of choosing a behavioural model for these studies in an early stage of the project is that it forced to focus, which is helpful but may also result in overlooking concepts that are positioned outside of the model (e.g. habitual behaviour).

Although our findings presented in chapters 3-6 confirmed the usefulness of the model for exploring determinants of communication behaviour, our findings did indicate that the first model should be adjusted. Several alterations in the model are

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**Figure 10.1:** Adjusted model regarding the communication behaviour of social insurance physicians (SIP) with work disability claimants (CL) during assessment interviews (chapter 2 described the original model).
therefore proposed, leading to the adjusted model presented in Figure 10.1:

- In the adjusted model, the communication behaviour of the physician is the central point of attention. This model aims to describe mainly the determinants of the communication behaviour of social insurance physicians, not those of claimants.
- The communication behaviour of claimants as perceived by social insurance physicians (i.e. the degree of respect and dominance in claimants’ communication behaviour) are conceptualised as determinants of communication behaviour of physicians. These were not included in the original model.
- The determinants of the communication behaviour of claimants (in the preparation phase) are not organised according to the TPB. The results of this thesis do not permit conclusions about the relationships between those determinants, other than that the combination of four of the determinants forms the three claimant types.
- Several determinants of the original model are not present in this model. For claimants, we found that attitudes were less important, while self-efficacy and social influence were more important than we originally thought. Also, skills seemed to be more important than barriers. For social insurance physicians, social influence was not as important as we originally thought and neither were skills. However, the other conceptualised determinants were found to be important.

Was it necessary to look at types of claimants and stereotypes?

One may argue that physicians do not use classifications of claimants (e.g. stereotypes or typologies) – as some of the physicians in the focus group study of chapter 6 stated – and that these classifications are not functional. There were three main reasons why this is unlikely, and why this was an important topic in this thesis. Firstly, studies outside of social insurance medicine have shown the opposite: physicians do use stereotypes and they need them in their work [1-4]. Secondly, because all claimants are different, physicians should be able to tune their behaviour to several kinds of claimant behaviour. Generalisations were found useful to order and condense these kinds of behaviour (chapter 6). Thirdly, we found that physicians were not aware of generalising and stereotyping during assessment interviews, while some claimants thought physicians do generalise at the expense of the assessment. More insight into this seemed desirable and was therefore a point of attention in the communication skills training course. For our study, focussing on classifications provided insight into how social insurance physicians view claimants’ communication behaviour (and its determinants). Also, it resulted in making the socially isolated claimant the main role for the actor enacting the claimant in the role-play during the training course.

Did we include the right populations in our studies?

An important point of attention in studies such as the ones that we have performed, in which participants are volunteers, is selection bias in participants. The physicians and claimants in our questionnaire studies (chapters 3, 4 and 5) and the physicians in the
focus group study (chapter 6) were perhaps more motivated and more positive (e.g. concerning the importance of research) than the total population of social insurance physicians and claimants. However, on background characteristics, such as age and gender, the participants did not differ meaningfully from the total population from which they were sampled. Nevertheless, due to selection bias possibly some determinants of communication behaviour or potential objectives for the training course may have been missed.

With regard to claimants, another point of attention is that predominantly Dutch claimants, who were fluent speakers of the Dutch language and had a high ability to read it, participated in the questionnaire study. Their distance to the social insurance physician (e.g. in socio-economic status) could be considered small compared to many of the claimants who are assessed by a social insurance physician. This means that our findings cannot be generalised to all claimants. Determinants of communication behaviour of non-Dutch speaking claimants with a low socio-economic status may be different and therefore the content of the training course may have been different if more of those claimants had participated in the studies. Probably, if we had been able to include more claimants with a low socio-economic status, the overall claimant satisfaction would have been less (especially because we found that the type of ‘insecure’ claimants was less satisfied).

Was satisfaction influenced by the conclusion of the interview?
It was impossible to incorporate the final outcome of the work disability assessment (i.e. the amount, if any, of the disability benefit) in the present study. However, it is probable that claimants’ opinions about the communication are influenced by how closely the outcome corresponds with what the claimant wants. Because both correspondence and non-correspondence may have occurred in our studies, we would expect these situations to average out (at least partially) in the research results.

Considerations regarding the intervention
Do physicians need a communication skills training course?
The results regarding the first objective showed that claimants were rather satisfied with the communication in the assessment interview. However, this does not mean that a communication skills training course has nothing to offer to social insurance physicians. Firstly, satisfaction may still be improved, all the more because claimants may file complaints concerning the communication. Secondly, physicians might have ‘blind spots’ (e.g. they may not realise that they give claimants too little time to respond to questions, let certain types of claimants ‘take over’ the interview, or forget that the interview may be a stressful situation for claimants) that complicate their assessment interview or lengthen its duration. These blind spots may surface during a training course. Also, many physicians working at the Dutch Institute of Employee Benefit Schemes have been working as a social insurance physician for many years...
and have not attended any specific communication skills training since they were appointed. It is likely that they have several fixed patterns outside of their awareness, which may influence the assessment. Thirdly, every physician has some part of his or her task that he or she finds hard, or some claimant behaviour that he or she finds difficult to respond to [5]. That may influence both the assessment interview and the job satisfaction of a physician. Fourthly, physicians who have just recently started to work as a social insurance physician may gain self-confidence and self-efficacy by attending a course of this type.

Was the two-day training course too limited as an intervention?
A comment of many participants in the communication skills training course was that they would have liked a continuation of the course or a follow-up day (booster session) a while after they had attended the course. They thought that it would be wise to practice what they had learned in real assessments and then get the opportunity to refresh what they had learned, ask questions about difficulties they had encountered, and share experiences with the other physicians in their group. To stimulate that the results of the course remain on the long term, such an additional course day may be of large value. Conversely, our review of literature (chapter 7) showed that a course should last at least one day to reach an effect, and the current course lasted two days.

A lot more topics would have been useful to address and for other topics more time could have been reserved. To realise this, one option would be to add another day to the training course, but we would not recommend this, because the participants were clearly full of information after two intensive training days in a row. Another option to increase the number of intervention days, is to expand the course to two blocks of two successive days with a week in between. However, this would decrease practical feasibility due to time restraints of social insurance physicians. We would therefore suggest to keep the training course a two-day course, and offer an additional follow-up training day after two or three months.

Should the control group have received an intervention as well?
Which topics should one address in a communication skills training that is not about communication? Because we could not think of any, we decided to make the control group a waiting-list group. Improvements in the intervention group may therefore not just be due to the content of the training course, but may also be partially due to attention of teachers and sharing time with colleagues with the same job and responsibilities. However, waiting-list control groups are often used in intervention studies [6-8]. Moreover, no changes in communication worth mentioning were expected without an intervention between the baseline and follow-up measurements, because the way social insurance physicians communicate can be considered a steady state (most of them have been working as social insurance physicians for many years already and few received any form of communication skills training in that working
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period). If we had had a control condition with a communication-related intervention, we would probably have found smaller differences between the intervention group and control group. However, we expect that the overall results would not have been different if the control group had received an intervention that was not related to communication.

**Should we have directed an additional intervention at claimants?**

Communication is a two-directional process. Perhaps most improvements in the communication can be expected if both the social insurance physician and the claimant would be made more aware of the importance of the communication during the assessment interview, and would be given guidelines for an effective, satisfactory communication. However, within the assessment interview, the physician is the professional and therefore he or she is the person primarily responsible for adequate communication. Nonetheless, teaching claimants about the assessment interview, what to expect, and how to provide information might enhance communication. Within the current thesis, only an intervention directed at physicians could be developed and tested, but there is other relevant research that addressed disability claimants, for example by ‘empowering’ them before they attend the assessment interview [9,10].

**Considerations with regard to the RCT**

**Was the study design appropriate for the evaluation?**

When we initiated this study, the original plan for the RCT was to evaluate the training on three primary outcome measures: acceptance of the claimant of the conclusions of the assessment, the opinions about the communication of social insurance physicians and the claimants, and the agreement of these opinions about the communication. To this aim, we planned to perform an RCT with 200 social insurance physicians (100 in the intervention and 100 in the control group) and at least 3 claimants per physician. Such an evaluation of effectiveness in practice would have been preferred over the current evaluation, but was not possible due to practical and organisational reasons far beyond our control (e.g. developments within the Institute of Employee Benefit Schemes, willingness of physicians and claimants to participate). Consequently, no firm conclusions about the effect of the training course on communication in the daily work of the physicians and on the opinions of claimants about the communication can be drawn.

Because we did a first evaluation of a newly developed intervention, perhaps another evaluation design – such as qualitative study or a study with a before-after design focussing on whether the course seemed capable to change actual behaviour in a smaller group of physicians – would have been more appropriate. However, then it would not have been possible to get insight into the results of the training course as we developed it, making sure a possible effect was not due to other factors than the
training course. This is especially relevant, because we only had time for one evaluation study.

More follow-up measurements, after the physicians attended the training course, would have made it possible to study whether physicians retain their competence and knowledge on the long-term. Unfortunately, within the time we had available, this was not possible. Therefore, the current RCT should be considered a starting point in the evaluation of the training course ‘Professional Claimant Communication’.

**Did we choose the right outcome measures?**
The primary outcome measures in the evaluation of the intervention (chapter 9) were competence and knowledge. To measure competence, we used a ‘paper-and-pencil’ test with a vignette. A real-life assessment (e.g. by performing structured observation or by consulting claimants) would probably have given a better approximation of actual communication skills in the assessment interview. However, due to practical, financial, and organisational issues beyond our control, this was not possible. Also, an evaluation of communication skills in an artificial environment, for example by instructing one or more actors for claimant roles and scoring the communication of the social insurance physician with standardised simulated claimants, was not possible. Therefore, we were forced to look into the options of a ‘paper-and-pencil’ method of evaluation, and within those restrictions, the current measures were the ones that most closely resembled reality. On the one hand, to measure competence this method may have given an underestimation of the effects of the course on communication skills, because it asks to denominate and explicate partly implicit skills. Therefore, physicians are likely to forget some aspects, which they would have shown in a real-life situation. On the other hand, it may have given an overestimation, because physicians may report saying or doing things in the communication, which they do not say or do in real practice.

To measure knowledge, multiple-choice questions were used. On the one hand, open-ended questions would have given a better representation of actual available knowledge. On the other hand, open-ended questions would have complicated valuing and comparing the responses of the participants. Probably, multiple-choice questions gave an overestimation of knowledge, because by chance already 50 percent of the answers would be correct. More answering options would have decreased the percentage correct by chance, but would also have made the questionnaire more lengthy. However, because we compared two groups (the intervention and control group) and there was no ceiling effect, these problems did not play any role in the results.
**Were the measurement instruments valid and reliable?**

An important problem for research in the field of insurance medicine is the lack of measurement instruments that are proven to be reliable and valid in the context of work disability assessment interviews. Within this thesis, we have pilot-tested all instruments in the target groups to assure content validity. Also, factor analyses were performed and only scales with an acceptable value of Cronbach’s Alpha were used in further analyses, to assure reliability. Although this makes these newly developed instruments promising for future research, it gives only a first indication of their validity and reliability. Possibly, we would have been able to identify more determinants of communication behaviour with better instruments. Also, better instruments for evaluating the training course would have permitted more firm conclusions.

**Were the results due to the intervention itself or due to the teachers?**

The effects that we found (chapter 9) were due to the total content of the training course, including the way in which the topics were addressed, the composition of the groups, the setting, and the teachers. To compare this with the literature: some researchers in psychology believe that the gains of training and therapy are due to non-specific factors, such as paying attention to a topic, the setting, and characteristics of the teachers [11-13]. Our evaluation was not designed to answer the question of which parts of it led to which improvements. However, it is likely that, if we had recruited teachers with another background, or teachers who were less enthusiastic, the results of the evaluation would have been different. This is an important point of attention for future implementation of the training course.

**Future research directions**

This study is – as far as we know – the first scientific study that has looked closely at the communication during work disability assessments from different perspectives. Also, it is the first study that has used scientific data to develop an evidence-based communication skills training course for social insurance physicians, and has evaluated that course. Clearly, much more scientific research is needed. The following directions for future research can be deduced from this thesis:

- More studies are needed on physician-claimant communication in social insurance medicine and on similar interventions in this setting to strengthen our findings, or to falsify them. This includes studies that increase insight into determinants of communication behaviour as well as studies about interventions to improve communication behaviour.
- The (adjusted) conceptualised model for communication behaviour, based on the TPB, should be investigated and validated further. Especially the following should be addressed:
From our results, it may be concluded that self-efficacy is an important determinant of both the physician’s and the claimant’s communication behaviour. More studies should focus on this determinant.

More research into the connections between the determinants of claimants’ communication behaviour is desirable.

Several important determinants are probably missing (e.g. habitual behaviour, automatisms), due to starting from the TPB-based model. Qualitative studies may give more insight into these presently unknown determinants.

Further psychometric and clinimetric research on the measurement instruments used in this thesis and other instruments for social insurance medicine in comparable and other populations of physicians and claimants is highly necessary.

The training course ‘Professional Claimant Communication’ should be optimised. Studies in which in-depth individual or group interviews with the participants are performed, or studies focussing on possibilities for improvement from a practical perspective may be useful for this. The current results indicate that the training approach used for the introduction phase of the assessment interview (the only phase for which competence became higher in the intervention group compared to the control group) is the most promising approach. This approach consisted of a short theoretical introduction, followed by individual role-play of all participants with video-recordings, a brainstorm about the necessary ingredients of the interview phase that is concerned, some more theoretical background, and looking at the recordings and discussing them with the whole group. It is important to study which parts of the intervention are the most useful, because physicians have limited time for training courses. The training course might also be further developed for other physicians.

For future developments, also, barriers for participation in a communication skills training course should be studied. We found that the prospect of having to perform role-play in the training course was not very attractive for many physicians. However, once they were attending the training course, all physicians participated in the role-play and everyone was enthusiastic about it at the end. In the course, this barrier was addressed by reserving relatively much time for creating a safe environment. It is likely that more barriers exist, which may be overcome quite easily once they are known.

A training course aimed specifically at claimants with a low socio-economic status, claimants who do not speak or understand Dutch, and claimants with a non-Dutch cultural background should be looked into in future research. These groups were underrepresented in the samples of this thesis.

When the (adjusted) training course is implemented, it is recommended to accompany this by further development and evaluation studies to gain more insight into its active ingredients and effectiveness.
If the intervention is proven to be effective, it would be interesting to study its cost-effectiveness. Several costs are involved for the Institute of Employee Benefit Schemes (e.g. time to attend for physicians, teachers, location), but there may also be benefits, for example resulting from less procedures for complaints and objections, faster assessments, and more work involvement of social insurance physicians.

Implications for social insurance physicians
The results of this thesis have several implications for social insurance physicians, their education, and work disability claimants.

Post-graduate education for social insurance physicians should include explicit attention to adequate communication in face-to-face contact with claimants. One important point of attention should be affective reactions in the communication (e.g. expressing empathy, showing understanding), because social insurance physicians tend to underestimate the importance of these affective reactions for claimants.

In pre- and post-graduate education for social insurance physicians, attention should be directed at the determinants that co-determine the communication behaviour, especially attitudes, self-efficacy, and barriers. Physicians should be made aware that these are important determinants of their communication behaviour. They should be encouraged to reflect on their own attitudes, self-efficacy, and barriers. In addition, physicians should be made aware of the determinants of claimants’ communication behaviour, which may help physicians to recognise the needs of claimants in the communication and meet those needs. Especially, the self-efficacy of claimants who are rather unfamiliar with the physicians they will meet needs attention.

In the assessment interview, physicians should explicitly pay attention to claimants’ potential insecurity regarding the communication, the expectations of claimants about the interview, and the social support the claimant has. Attention to potential insecurity may be an obvious thing to do if claimants seem insecure and submissive in their communication behaviour, but it is also important for claimants who show dominant communication behaviour. Physicians should be aware of the potential importance of other people in the direct surroundings of their patients, and this should be addressed in their education.

General education as well as communication skills training courses for social insurance physicians should include active, practice-oriented training strategies. In medical education role-play with feedback is already used a lot. The current results show that this is legitimate. Even though we found that initially social insurance physicians might be hesitant to participate in role-play, if a safe environment is created, then physicians will participate and open up to learning.

To make a communication skills training course for social insurance physicians successful, all stakeholders should be consulted during its development, planning and
implementation. We experienced that potential pitfalls of the course itself may be identified and solved in an early stage. Also, conditions for success are more likely to be created when the expertise of these stakeholders is used.

The training course ‘Professional Claimant Communication’ should be offered again in the future, paying attention to possible points of improvement. The course could be implemented within the Educational Department of the Institute of Employee Benefit Schemes, but possibly also within the Netherlands School of Public and Occupational Health. This thesis has resulted in an almost ready-to-use intervention addressing communication in the context of social insurance medicine, which may help to further promote and improve adequate communication behaviour. To let physicians and claimants benefit from these results, the course should be implemented in practice. By developing the course in collaboration with the Educational Department and using their infrastructure, the way is paved for a successful implementation.

Possibilities should be created for one follow-up training day for participants a couple of months after they have attended the training course. Possibly, this can be realised by connecting to the new development within the Institute of Employee Benefit Schemes to offer supervision to social insurance physicians [14]. Sustainable effects in everyday life practice are more likely to occur when the taught knowledge and skills are refreshed regularly [15].

Relevance for physicians in general
A lot of effort is put into continuous learning to maintain competence (and licenses) throughout the whole medical career. Our findings about determinants of communication behaviour and the developed communication skills training course may also be used in this respect.

The face-to-face communication between physicians and patients is an important topic, both from a practical and a research perspective. Both instrumental and affective reactions of physicians are important for patients. Physicians may tend to focus more on instrumental reactions than on affective reactions, because their emphasis is on getting and giving information about illness and health. Therefore, they may neglect to react towards patients in an affective way and may underestimate the importance that patients attach to affective reactions.

Insight into what (co-)determines communication behaviour of both physicians and patients may increase the insight into conditions for adequate physician-patient communication, and into possible opportunities to adjust this behaviour if necessary. We found that attitudes, self-efficacy, and barriers are important determinants of behaviour. Also, the degree of insecurity that patients experience about the communication, as well as their expectations about the communication may influence the communication, especially when the physician is not able to adequately pay attention to this. In addition, the social support that claimants have of important
persons in their lives during stressful moments (such as a consultation with a physician) is an important indicator of their instrumental and affective needs in the communication with physicians. Physicians may underrate this importance, and do not realise that being ill and feeling blue – or even depressed – may increase the need of social support in patients.

Communication skills are an important topic to address in post-graduate education for physicians. General communication and conversation techniques of physicians may need refreshment from time to time. Physicians will probably enjoy and appreciate such a course, if the right conditions are created (e.g. a safe learning environment). In addition, more specific communication skills – such as those necessary for introducing oneself and ones tasks adequately, and closing the consult while at the same time properly dealing with highly emotional issues – are important to pay attention to in communication skills training courses for physicians.

Conclusions

Conclusions on objective I
The first objective of this thesis was to explore the determinants of communication behaviour of social insurance physicians during assessment interviews for disability benefits, as well as those of work disability claimants. We conclude that:

• The TPB-based theoretical model can be functional in helping to understand the communication in the preparation phase before an actual assessment interview takes place.
• Intentions (to give information and to consider personal aspects), attitudes, self-efficacy, and barriers of social insurance physicians seem relevant determinants of their communication behaviour in assessment interviews.
• For claimants, their self-efficacy, skills, social support, and intentions with regard to the communication seem the most relevant determinants of their behaviour, and these can be combined into three ‘stereotype’ behavioural descriptions of claimants (i.e. insecure support-seeking, confident, socially isolated).
• Claimants themselves tend to have somewhat negative expectations about the assessment interview (in the preparation phase). Afterwards, however, they are generally satisfied with the communication during the actual interview. Physicians, on their turn, think that claimants are more satisfied than they actually are.
• In the actual assessment interview, the most important determinants of the communication behaviour of claimants, according to social insurance physicians, are the degree of respect that claimants show in the physician-claimant relationship and claimants’ dominance in the communication.
Conclusions on objective II

The second objective of this thesis was to develop a post-graduate communication skills training course for social insurance physicians (from the results of the first objective and additional information) and to evaluate it. We conclude that:

- Training courses of this type should include predominantly active, practice-oriented training strategies, such as role-play and group discussion.
- Developing a communication skills training course by including the opinions and experiences of all relevant stakeholders, resulted in a course of which the feasibility and practical relevance are promising.
- Although this course needs some improvements and more research concerning the measurement instruments is needed, it was able to increase physicians’ competence in introducing themselves and their tasks in the assessment interview, and to increase their knowledge about the communication.
- The social insurance physicians who participated in this training course were unanimously very positive about its contribution to communication in work disability assessment interviews.

References


