Assessment of Doctor-Patient Communication Skills Omdurman Friendship Teaching Hospital (OFTH) August-2010

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Abstract: Communication is the procedure of generation, transmission, or gathering of messages to oneself or another substance, for the most part by means of a commonly comprehended arrangement of signs. Communication skills are the tools that individuals use to evacuate boundaries and troubles to perform successful correspondence (are learnable, trainable, versatile simply like some other expertise). The objective was to assess the effectiveness of the communication skills system among consultants, physicians, registrars and medical officers with their patients in different units of medicine and surgery.

Methods: It was a descriptive-analytical study in OFTH August 2010. (241) participants by simple random sampling. All patients attend the OFTH for their appointment and agreed to be included in this study. Whereas the emergent and urgent were excluded. Data were collected using small groups discussion and pre-tested questionnaires.

Results: Many doctors know some information about Doctor-Patient Communication Skills but, they didn't perform it because of, the high frequency of patients in referral clinics. Doctors spent 6 to 10 minutes with 179 patients (74.3%), 11to 15 minutes with 46 patients (19.1%), 1 to 5 minutes with 12 patients (5%), 16 to 20 minutes with 3 patients (1.2%) and more than 26 minutes with one patient (0.4%). Patients' satisfaction; 205 patients are satisfied represent (85.1%), 36 patients aren't satisfied represent (14.9%). Those who aren't satisfied; 25 patients (69%) because of a short duration of the medical interview, 8 patients (22%) because doctors didn't mention the adverse effects of the drugs and 3 patients (9%) because doctors didn't mention the possible complications of the operation.

Conclusion: Doctor-patient communication skills were done by medical officers, registrars, physicians, and consultants. They took a short time 6-10 minutes for the medical interview (74.3%), they didn’t share information with their colleagues in the same unit by (46.5%) in 112 patients and didn’t involve other healthcare professionals in patients’ care by (62.7%) for 151 patients. Despite that, the patients’ satisfaction was (85.1%)

Keywords: Communication; Doctor; Omdurman Friendship Teaching Hospital; Patient; Relationship; Satisfaction; Skills; Interview.

Introduction and literature review

Communication is the system of generation, transmission, or social event of messages to oneself or another substance, generally by methods for a usually appreciated course of action of signs. Relational abilities are the apparatuses that people use to empty limits and issues to perform effective correspondence (are learnable, trainable, flexible just like some other mastery). The human correspondence was improved with the origination of talk around 500,000 going before right now. Images were made around 30,000 years prior. (1) The communication process includes the sender, encoding, the channel, decoding, the receiver, feedback, and the context. To be a compelling
communicator and to express what is on your mind without misconception and disarray, your objective ought to be to reduce the recurrence of issues at each phase of this procedure, with clear, brief, exact, well-arranged correspondences. As the source of the message, you should be clear concerning why you're imparting, and what you need to convey. You likewise should be sure that the data you're imparting is valuable and exact. The message is the data that you need to convey. Encoding is the way toward moving the data you need to convey into a structure that can be sent and effectively decoded at the opposite end. Your achievement in encoding depends incompletely on your capacity to pass on data obviously and essentially yet in addition to your capacity to envision and dispense with wellsprings of disarray (for instance, social issues, mixed up presumptions, and missing data.) A key piece of this is knowing your crowd: Inability to comprehend who you are speaking with will bring about conveying messages that are misjudged. Channel; messages are passed on through stations, with verbal stations including eye to eye gatherings, phone and videoconferencing; and composed channels including letters, messages, updates, and reports. Various channels have various qualities and shortcomings. For instance, it's not especially powerful to give a considerable rundown of bearings verbally, while you'll rapidly cause issues if you give somebody negative input utilizing email. Decoding; similarly, as effective encoding is an ability, so is fruitful translating (including, for instance, setting aside the effort to peruse a message cautiously, or listen effectively to it.) Similarly, as disarray can emerge from blunders in encoding, it can likewise emerge from unraveling mistakes. This is especially the situation if the decoder needs more information to comprehend the message. Receiver; your message is conveyed to singular individuals from your group of spectators. Almost certainly, you have as a primary concern the activities or responses you trust your message will get from this group of spectators. Remember, however, that every one of these people goes into the correspondence procedure with thoughts and emotions that will without a doubt impact their comprehension of your message and their reaction. To be a fruitful communicator, you ought to consider these before conveying your message and act properly. Feedback; your group of spectators will give you criticism, as verbal and nonverbal responses to your imparted message. Consider this input, as it is the main thing that can give you certainty that your group of spectators has comprehended your message. If you find that there has been a misconception, in any event, you have the chance to send the message a subsequent time. Context is the circumstance where your message is conveyed is a specific situation. This may incorporate the encompassing condition or more extensive culture (corporate culture, worldwide societies, etc.).

Communication Models include:

The biomedical model where the specialist is responsible for the conference and spotlight is on infection the executives.

The patient-focused model attempts to accomplish a decent harmony between clinician posing the inquiries expected to incorporate or bar analyze, patients were approached to express their thoughts, concerns, desires and their sentiments, and clinicians clarifying and exhorting in manners patients can comprehend and be engaged with choices. Along these lines, the key focuses to investigate the ailment and patient's understanding, comprehend the entire individual (counting family, social condition and convictions), discover shared opinions on the executives, set up the specialist persistent relationship, and be reasonable; needs for treatment; resources. (3) The professionals of good correspondence incorporate improved wellbeing results, tolerant security, time the executives, cost, adherence, quiet clinician fulfillment, and diminished case. While the cons of poor correspondence are an inability to recognize issues, specialist persistent disappointment, and lawsuits. (4) Communication skills types are verbal characterizes as the ability to explain and present your considerations in clear language, to varying observers. This fuses the ability to tailor your transport to a given gathering of onlookers, using fitting styles and approaches, and an understanding of the centrality of non-verbal prompts in oral correspondence. Oral correspondence requires the establishment of aptitudes of presenting, gathering of onlookers' care, fundamental tuning in and non-verbal correspondence. Non-verbal is the ability to redesign the presence of musings and thoughts without the use of smart imprints, utilizing non-verbal correspondence, movements, outward appearances and way of talking, and besides the use of pictures, images, and pictures. It requires establishment aptitudes, for instance, swarm care, singular presentation, and body language. (5) Equipped for the future fundamentals (EFF) incorporate relational abilities, for example, read with cognizance, pass on musings recorded as a printed copy, talk so others can appreciate, listen
adequately, and observe in a general sense. Basic leadership aptitudes, for example, handle issues and choose, plan, use math to deal with issues and pass on. Relational abilities, for example, take an interest in others, control others, advertiser and effect, resolve battle and organize. Deep-rooted learning aptitudes, for example, expect risk for learning, learn through research, reflect and evaluate, use information and exchange innovation.\(^6\)

**Questioning procedures/techniques:** pose inquiries viably lead agreeable to the patient. A shut inquiry, as a rule, gets a solitary word or extremely short, verifiable answer is useful for testing your comprehension, or the other person’s, finishing up a dialog or choosing, and frameset. A lost shut inquiry, then again, can slaughter the discussion and lead to clumsy quiets, so are best maintained a strategic distance from when a discussion is in full stream. Open inquiries inspire longer answers, for the most part, start with what, why, how is useful for building up an open discussion, finding our more detail, and discovering the other individual's feelings or issues. Funnel question includes beginning with general inquiries, and afterward homing in on a point in each answer and asking increasingly more detail at each level. It’s regularly utilized by criminologists taking an announcement from an observer. Examining/probing questions use addresses that incorporate "precisely" to test further. The successful method for testing is to utilize the 5 Whys strategy, which can help you rapidly get to the foundation of an issue is useful for picking up explanation to guarantee you have the entire story and that you comprehend it altogether; and coaxing data out of individuals who are attempting to abstain from revealing to you something. Driving/leading inquiries attempt to lead the respondent in your mind. It will, in general, be shut. Are useful for finding the solution you need however leaving the other individual inclination that they have had a decision. Facetious/rhetorical inquiries are considerably progressively ground-breaking on the off chance that you utilize a string of them, they aren't generally addressing by any stretch of the imagination, in that they don't anticipate an answer. They're simply articulations expressed being referred to frame and are useful for drawing in the listener.\(^2\)

**To convey viably you should:** tune in to patients, ask for and respect their points of view about their prosperity, and respond to their stresses and tendencies. Offer with patients, in a way they can fathom, the information they need or need to consider their condition, its possible development, and the treatment options available to them, including related perils and vulnerabilities. Respond to patients' requests and keep them instructed about the progression of their thought. Guarantee that patients are taught about how information is shared inside gatherings and among the people who will give their thought. You ought to guarantee, wherever practical, that approaches are made to meet patients' language and correspondence needs.\(^7\) Upgrading your interchanges by utilizing signals, eye to eye connection, outward appearances, pose, apparel is critical to reflect regard for the estimations of your association and keep reasonable individual space.\(^2\) Working in groups with partners in this way, regard, contribute, don't embarrass, convey adequately, ensure that your patients and partners comprehend your job and obligations in the group, and bolster associates who have issues with execution, lead or health.\(^7\) The knowledge and utilizing clinical ethic reinforce the connection between clinicians and individual patients. The four key standards are every now and again utilized. Self-sufficiency: regard for the people and their capacity to settle on a choice with respect to their own wellbeing. Regard for people and their self-governance has significant ramifications for truth-telling, educated assent, and secrecy. Truth-coming clean with advising is basic to produce and keep up trust among specialist and the patient. Educated assent portrays the interest of patient choices about their medicinal services. To encourage this, the clinician must give them enough clarification of the nature of the choice, and subtleties of the applicable dangers, advantages, and vulnerabilities of every conceivable strategy. The measure of data to give will change, contingent upon the patient’s condition and unpredictability of treatment, and on the specialist's evaluation of the patient's comprehension of the circumstances. Not all alternatives need be clarified, however, those that (judicious patient) will consider critical ought to be investigated by open inquiries. From both a lawful moral viewpoint the patient returns the privilege to choose what is in his/her wellbeing. Secrecy Human services group must play it safe to anticipate unapproved access to patient’s record and may reveal tolerant recognizing data just when the patient has given assent. Never enlighten anybody concerning a patient except if it is straightforwardly identified with their consideration. Value: acting to the advantages of the patients. It is a rule of progressing admirably. Non-perniciousness: acting to counteract mischief to the patient. It is a standard
of doing no damage. Equity: decency to the patient and the wide network while thinking about the results of an activity. It identifies with conveyance of restorative consideration and assignment of assets. The idea of a reasonable conveyance of social insurance can be seen from three keens; regard for the requirements of the individual, regard for the rights and regard for merit.\(^{(7)}\)

**Breaking Terrible News:** the awful news is any sort of data that changes the patient's perspective on what's to come. The edge SPIKES show the means

**S-Setting:**
- a. See the patient at the earliest opportunity once the present data has been assembled.
- b. Ask not to be upset and handover bleeps to partners.
- c. If conceivable, the patient ought to have somebody with them.
- d. Choose a tranquil spot with everybody situated, present everybody.
- e. Indicate your status and the degree of your duty toward the patient and the time accessible.

**P-Discernment:**
Prior to telling, ask what has befallen the patient since the last arrangement, what have they been told or understood up until this point and how have they responded. This stage helps measure the patient's discernment however ought not to be to draw out.

**I-Greeting:**
- a. Demonstrate you have the outcomes and inquire as to whether the patient needs you to clarify.
- b. Evaluate how much the patient might want to know.
- c. If patients don't need subtleties, offer to respond to any inquiries they may have later or to converse with a family member or companion.

**K-Information:** If the patient wishes to know:
- a. Give the admonition to enable the patient to get ready: (I'm apprehensive it looks more genuine than we trusted). At that point give the subtleties.
- b. At this point Pause: enable the patient to think, and possibly proceed with when the patient gives some lead to pursue. This interruption may have a place one normally only minutes, while considerations go around in the patient's head, and are frequently joined by closing which makes patients unfit to hear any things further until these musings settle down.
- c. Give the data without fudging, in little lumps. Maintain a strategic distance from specialized terms. Check to see regularly. Watch for signs the patient can take no more.
- d. Emphasize that a few things, for instance, torment and different manifestations, are fixable and others are most certainly not. Abroad time span can be given for the fixable part of care.
- e. Be arranged for the inquiry (to what extent do I have?). Keep away from the snare of giving a figure which is best to be erroneous. There are no simple answers, and this is the place preparing can help practice reactions that work for every clinician. Regular deficiencies are to be excessively hopeful. Stress the significance of guaranteeing that personal satisfaction is made on a par with conceivable from day today.
- f. Provide some positive data and expectations tempered with authenticity.

**E-Compassion:** reacting to the patient's feelings is about the human side of the medicinal mind and furthermore help patients to take in and conform to troublesome data. Orchestrate of feelings is knowledgeable about truly and critically ill patients (Gloom, Refusal, Outrage, Bartering, Melancholy or Acknowledgment).
- a. Be arranged for the patients to have messy enthusiastic reactions or some likeness thereof. Recognize them at an early stage as being what you expect and comprehend and sit tight for them to settle before proceeding.
- b. Crying can be a discharge for certain patients. Permit time if the patient needs it instead of surging in to stop the crying.
- c. Learn to pass judgment on which patients wish to be contacted and which don't. You can generally connect and contact their seats.
- d. Always keep an eye out for shut down.
- e. Keep stopping to enable patients to think and casing their inquiries.
- f. Stop the meeting if vital and orchestrate to continue later.

**S-Technique and Rundown:** Patients who have an unmistakable arrangement for the following and future advances are less inclined to feel on edge and unsure. The clinician must guarantee that:
- a. The tolerant has comprehended what has been examined because points of view are muddled are seasons of feeling and misguided judgments can flourish.
- b. The persistent records pivotal data to remove.
c. The tolerant realizes how to contact the suitable
colleague and consequently has a wellbeing net
set up, the following meeting date-ideally soon-
has been concurred, for what reason and with
whom.
d. Family individuals are welcome to meet the
clinicians as the patient wishes are composed of
the material or further wellsprings of data are
promptly accessible.
e. Everyone is said farewell, beginning with the
patient.

Follow up: Terrible news is a procedure and not a
unique case. Patients may not recall everything from
the last visit and recapping is essential. Continuously start by asking patients what they
have seen so far-it is amazingly troubling for
patients to hear various things from various patients.
Keep partners educated and archive precisely
information exchanged. The move from dynamic
treatment to palliative consideration is a
troublesome stage in awful news. Patients what to
recognize what occurs straightaway. Offer clear
responses with affirmation. The clinician's job is to
intervene between the patient, other restorative staff
and the patient's family members while proceeding
to be a sympathetic and minding doctor. (4)

Frameworks

Structures and Skills for Effective
Communications

Framework 1; Interview

- Build the Relationship: Because patients are
frequently anxious and may feel unwell.
Building the relationship is the first stage in an
interview. Non-verbal communication is a
powerful element.

- Open the Discussion: The aim is to obtain all the
patients' concerns, remembering that they
usually have at least three (range 1-12). Ask
(what would you like to discuss today?) or (what
problem have you brought to see me today?).
Listen attentively without interrupting. Only
when all concerns are identified can the agenda
be prioritized, balancing the patient concerns
with the clinician's main points of interest.
Contain complete history by attentive listening
which is necessary communication skills and
questing style which start with open questions
and move to screen, focus and closed questions.

- Understand the patient's perspective: Find out
the patient perceptive is an essential step
towards achieving common ground

- Sharing information: The key is to tailor the
information to both what the patients want to
know and the detail they prefer as this help to
understand.

- Reach agreement on problems, plans, and
management: Once the patient has understood
the information the clinician and patient need to
agree on the best course as regards possible
investigation and treatment. Negotiating the next
steps-enlisting the patient's collaboration.
Summarizing: this allows the patient to correct
or add information and correct any
misunderstanding. It is a feature of share
decision making and good practice.

- Providing closure: The closing stage of the
interview. Plan for follow-up and informing
other health professionals involved in patient
care are confirmed. (4)

Framework 2; Communication skills

- Attitudes: patients want someone who is
confident, friendly, competent and trustworthy.

- Personal appearance; clothes, hair, make-up,
shoes... etc.

- Timing; choose a suitable time, try to avoid time
during eating, drinking, when the patient lost a
friend or a relative…. etc.

- Setting: quiet room, a chair, table …etc.

- Avoid medical jargon, anger, irritation,
criticism, cynicism, scorn, paternalism,
distorted, not amenable to reason, asymmetrical
perception or not listening/hearing.

- Be; trust, respect, autonomy, realistic,
reasonable, common vision, listening/hearing,
clarity, calm and praise.

- Remember the name of your patient.

- Standing

- Greeting

- Shaking hands, if you are going to break bad
news say hello.

- Demeanour; give the patient your full attention,
appear encouraging in a warm friendly manner.

- Define your role; who you are, what your role
is, who your seniors.

- Style of questioning; open, close, clarifying…

- Reflective comments; use it to encourage the
patient to go on and reassure them that you are
following the story.

- Staying on topic; do not be afraid to interrupt
the patient, when you are going to move him/her
to another topic-some patient talk for hours if
you let him/her.
• Difficult questions; apologize for potentially offensive or embarrassing questions.
• Eye –contact; look to the patient during the speaking.
• Adjusting your manner; you would Cleary not talk to another doctor as you would someone with no medical knowledge so, adjust according to the patient's educational levels.
• Interruptions; apologize to the patient if interrupted.
• Do not take offense or get annoyed; this will affect the thought of your patient. \(^{(3)}\)

**Framework 3: Communication skills**

• Approach to the patient; You should: Introduce and orientate the patient and yourself. Establish an attentive, respectful and non-judgmental relationship. Acknowledge the patient's emotions and concerns
• Listening, questioning and diagnosing; You should: Ensure you have understood the patient's symptoms/problems and concerns. Summarize and clarify understanding
• Explaining and advising; You should: Enable the patient to understand the problem/situation. Reassure appropriately. Summarize and clarify understanding
• Involving the patient in the management; You should: Explore the patient's expectations/concerns. Propose/explain the management plan clearly. Explore the patient's response. Respect the patient's autonomy and help him or her to decide based on available information and advice. Summarize and clarify understanding. \(^{(2)}\)

**Barriers and challenges in communications;** the principal factor is clinician factors as found in; Absence of information on impact and predominance of psychosocial matters in disease and its recuperation. Aptitudes; utilizing separating strategies to keep away from troublesome points, utilizing language and absence of empathy. \(^{(4)}\) The frame of mind and convictions: absence of trust, regard, self-rule, practical, sensible and regular vision notwithstanding utilizing criticism, disdain, paternalism, misshaped, not manageable to reason and deviated discernment. Practices and jobs: the absence of tuning in/hearing, lucidity, quiet and commendation. Utilizing a fast approach, language, outrage, bothering, and criticism. \(^{(8)}\) The subsequent factor is troublesome patients circumstances in restorative experiences, for example, wandering or chatty, ambiguous, discouraged or pitiful, furious, on edge, needy, requesting, emotional or manipulative, masochistic, lenient, precise and controlled, fretful, hyper, watched neurotic, predominant, thinking about passing on, unraveling clashes, clashed jobs, hearing/visual/discourse impedance, understanding with somatization, and breaking awful news. \(^{(2)}\) The third factor is shared elements like diverse first language, absence of security, absence of time and distinctive social backgrounds. \(^{(4)}\) Shrouded plans, partialities, and defensiveness. \(^{(9)}\) Successful correspondence is a fundamental piece of building and keeping up great doctor-patient and doctor partner connections. These aptitudes help individuals to comprehend and gain from one another, create substitute points of view, and meet each other's needs. \(^{(9)}\) Relational abilities in a social insurance setting incorporate clarifying conclusion, examination, and treatment, including the patient in the basic leadership, speaking with family members, speaking with other human services experts, breaking awful news, looking for educated assent/explanation for an obtrusive strategy or acquiring assent for a posthumous, managing restless patients or family members, giving guidelines on release, and offering guidance on way of life, wellbeing advancement or hazard factors. \(^{(9)}\)

**How to improve relational abilities?** By showing yourself these abilities, learn them, receive them, and make them part of the new you. \(^{(9)}\)

Study appeared by Medscape Restorative News improving relational abilities upgrades effectiveness and patient-clinician connections. In May 1999, at a meeting supported by the Bayer Establishment for Wellbeing Interchanges and the Fetzer Foundation, a specialist board distinguished 7 parts viewed as basic to all experiences among clinician and patient form the relationship, open the discourse, assemble data, comprehend the patient's viewpoint, share data, agree on issues and designs, and give conclusion. Study Features that the specialists analyzed PubMed, EMBASE, and Psych Data for clear or test examine distributed somewhere in the range of 1973 and 2006. Included research concentrated on quality-upgrading understanding clinician relationship and relational abilities that were likewise connected with productivity. Effectiveness was characterized by no expansion in the length of the patient consideration visit. 1146 investigations were found in the scientists' unique pursuit. 9 references met the consideration criteria, just 1 of which was trial in plan. The 9 examinations were restricted by little example sizes and inability
to inspect patient and clinician fulfillment or wellbeing results. From restorative writing, the writers discovered 3 spaces that were related to correspondence quality and proficiency. They likewise included 1 segment that they chose was important to finish a solid correspondence model. These 4 spaces are; Compatibility building incorporates a warm welcome, eye to eye connection, and a brief nonmedical collaboration. The careful practice incorporates mindful perception of the patient and of the clinician's own point of view. Furthermore, the objective is to prepare for subjective easy routes and clinician strength of the motivation. Theme following incorporates patients' and clinicians' consent to concentrate on a point, ideally at the start of the visit. Recognizing social or enthusiastic pieces of information with compassion that implies the compassionate affirmation of patient signs may evoke convictions about sickness and treatment inclinations. Likewise, sympathy may advance patient self-adequacy. Other significant focuses, for example, gathering analytic data from the patient might be joined with a comprehension of the patient's point of view on the current subject. Investigation of patient convictions and inspiration can be practiced from 30 seconds to 5 minutes. Patients associated with the formation of the treatment plan are increasingly fulfilled and have better results. Plans ought to be custom-made to represent patients' monetary and social assets just as patients' preparation to change. Thus, the pearls for training incorporate solid patient-clinician correspondence and connections that are related to better wellbeing results, diminished medicinal expenses, and a diminished hazard for negligence claims. Longer center visits don't really improve correspondence. The present survey recommends that the 4 areas of value and proficient patient-clinician correspondence and relationship building are compatibility building, careful practice, theme follows, and the affirmation of social or passionate prompts with empathy. (10) The doctor is an expert at the same time, the calling is work needs ceaseless information on some division of learning or science. (11)

Legitimization and method of reasoning: communication skills are a craft of medication and assume a significant job in building specialists understanding relationships to arrive at finding fitting administration, great clinical results, and further development. The investigation was not featured in Sudan although it is a global framework and vital. The general goal to survey the relational abilities framework among specialists, doctors, enlistment center and therapeutic officials with their patients in various pieces of medication and medical procedures. The particular goals to decide the compatibility and relationship working, to evaluate the comprehension to the patient's point of view, to decide the way toward sharing thoughts, assembling and offering data to the patient and associates, to survey the recognizing of social or feeling signs of the patient with sympathy, to decide the specialist understanding exchange, agreeing on issue/s, plans and the executives, to survey the giving conclusion through; plans for development and advising other medicinal services experts engaged with the patient consideration are included, and to decide the patient fulfillment.

Material and methods
Descriptive analytical study for all patients, attending to OFTH August 2010 seeking health in the selected days according to referral system (outpatients’ clinics); 241 participants by simple random sampling.

Inclusion criteria: All stable patients attending to OFTH seeking health care in all different units of medicine and surgery.

Exclusion criteria: All emergent and urgent cases attending to OFTH are excluded.

Methods of data collection: Data were collected by the following tools:
Pre-tested questionnaire (annex 1) and Focus groups discussion with medical personnel (annex 2)

Recruitment and Training of Field Workers: The field team consisted of 4 medical doctors. Intensive training for a week was given to the field personnel to educate them about the quality of data collection.

Data analysis and management: Data processing was carried out at the computer using SPSS program

Ethical consideration and clearance: Were taken from the general medical director and verbally to all doctors and patients.

Results
Most doctors know some information about doctor-patient communication skills but, they didn't perform it as recommended by text and guidelines because of, the high frequency of patients in referral clinics. In this study 241 patients, most cases were seen by consultants 104 (43.2%), 77 patients (32%) by medical officers, 55 patients (22%) by registrars
and 5 patients (2.1%) by both medical officers and consultants.

**Fig. (1)** showed the distribution of the patients according to their duration of the medical interview in OFTH -August -2010

Regarding duration of medical interview as shown in figure(1) most doctors spent 6 to 10 minutes with 179 patients (74.3%), then 11to 15 minutes with 46 patients (19.1%), then 1 to 5 minutes with 12 patients (5%), then 16 to 20 minutes with 3 patients (1.2%) and more than 26 minutes with one patient (0.4%). Concerning warm greeting, 213 patients (88.4%) received it, while 28 patients (11.6%) not received it. As well as all the patients listened to them attentively, 240 patients (99.6%) with eye to eye contact, one patient (0.4%) without it, 170 patients (70.5%) were interviewed without brief nonmedical interaction and 71 patients (29.5%) with brief nonmedical interaction. All doctors understood all patients and shared information and ideas with all of them. While in 129 patients (53.5%), doctors shared information and ideas with colleagues, in 112 patients (46.5%) didn't share information and ideas with colleagues. In addition, doctors acknowledging social or emotional clues to all patients, removing barriers to 240 patients (99.6%) and negotiate all patients reaching agreement on problems and on plan and management. Doctors providing closure plans for following all patients and providing closure informing other health care professionals involved in patient care to 90 patients (37.3%) and not to151 patients (62.7%). Regarding patient satisfaction, 205(85.1%) of them are satisfied, while 36 (14.9%) of them aren't. 25 patients (69%) aren't satisfied because of, the short duration of medical interview, 8 patients (22%) because of, doctors didn't mention the adverse effects of the drugs and 3 patients (9%) because of, doctors didn't mention the possible complications of operation as shown in table(1)

**Table (1):** showed the distribution of patients according to the reasons of dissatisfaction in OFTH-August- 2010

<table>
<thead>
<tr>
<th>Reason of Dissatisfaction</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The short time of medical interview</td>
<td>25</td>
<td>10.40</td>
</tr>
<tr>
<td>Doctors didn't mention the side effects of the drugs</td>
<td>8</td>
<td>03.30</td>
</tr>
<tr>
<td>Doctors didn't mention the possible complications of the operation</td>
<td>3</td>
<td>01.20</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>14.90</td>
</tr>
</tbody>
</table>

**Discussion**

At the point when the patients arrived at the OFTH they began to enlist their names in the therapeutic record office in order to see the referral facility. This framework gave exhaustive medicinal services to all ages, both genders and any infection element to pursue their conditions for best results and patient fulfillment. In this examination, the working staff didn't stand when the patient landed at their office and didn't ask the patient utilizing his/her name. Studies demonstrated recollecting the name of your patient is basic in correspondence skills. All specialists didn't remain to meet and welcome the patient. Studies demonstrated remaining to meet and welcome the patient is a component of correspondence skills. In regard to the outward presentation of the specialists (garments, hair and make – up....), some of them showed up great, some in a typical way and some of them without sterile garments Studies indicated Garments is significant. By dressing for your activity, you show regard for the qualities and shows of your organization, another investigation indicated the outward presentation (garments, hair, make-up, and shoes) is a significant advance in correspondence skills. In regard to, interference of restorative meetings and manner like utilizing portable; most specialists utilized the versatile when it was ringing. Studies demonstrated to give the patient your complete consideration and apologize to the patient if interrupted. All specialists didn't acquaint
themselves with the patients. Studies indicated characterize your job; what your identity is, the thing that your job is, who your seniors are significant in correspondence skills (3), just as present and orientate the patient and yourself. (4) Concerning terrible news, the specialists told the co- understanding first then after certain days or weeks they are told the patient. Studies appeared there is an arrangement causes clinicians to show awful news in verifiable, unhurried, balance and empathic style that reaction to every patient. The S-P-I-K-E-S strategy. (4) The working staff didn't play out the relational abilities precisely and in a perfect world as in the system. (2-4) The of span of restorative meeting, was exceptionally short and deficient, the most elevated recurrence of patients was met in 6-10 minutes, they were 179 speaking to (74.3%), at that point 46 patients (19.1%) were met in 11-15 minutes, at that point 12 patients (5%) were met in 1-5 minutes, then 3 patients (1.25%) were met in 16-20 minutes and one patient (0.4%) was met in a short time. Concentrates demonstrated one of the primary reasons referred to by clinicians for poor correspondence and relationships working with patients is the absence of time. (10) Concerning warm welcome, 28 patients (11.6%) not got it; though welcome or shaking hands is the initial step to begin correspondence skills. (3) 170 patients (70.5%) were met without brief nonmedical collaboration. Studies indicated assembling relationship is the principal component in correspondence skills. (4) Another investigation demonstrated compatibility building incorporates a warm welcome, eye to eye connection, and a brief nonmedical collaboration is the primary principle part for solid correspondence skills. (10) The component of offering thoughts and data to associates, the specialists didn't impart to partners in 28 patients speaking to (73.7%). Giving conclusion advising other social insurance experts engaged with tolerant consideration didn't do to 151 patients (62.7%). Studies appeared; ensure that patients are educated about how data is shared inside groups and among the individuals who will give their care. (7) In regard to understanding fulfillment, 36 patients (14.9%) aren't fulfilled. 25 patients (69%) aren't fulfilled on account of; the brief span of therapeutic meeting, 8 patients (22%) as a result of, specialists didn't make reference to the antagonistic impacts of the medications and 3 patients (9%) in light of, specialists didn't make reference to the potential inconveniences of activity. Studies appeared in May 1999, at a meeting supported by the Bayer Establishment for Wellbeing Correspondences and the Fetzer Foundation, a specialist board recognized 7 parts viewed as key to all experiences among clinician and patient: form the relationship, open the dialog, accumulate data, comprehend the patient's point of view, share data, agree on issues and designs, and give closure. (10) Studies appeared from therapeutic writing, the writers discovered 3 areas that were related to correspondence quality and productivity. They likewise included 1 segment that they chose was important to finish a solid correspondence model. These 4 spaces are outlined underneath:

Affinity working by a warm welcome, eye to eye connection, and brief nonmedical cooperation. The careful practice incorporates; mindful perception of the patient and of the clinician's very own manner of thinking here the objective is to prepare for subjective alternate routes and clinician strength of the plan. Subject following by means of patient and clinician consent to concentrate on a specific theme, ideally at the start of the visit. Recognizing social or enthusiastic intimations with sympathy; the sympathetic affirmation of patient signs may inspire convictions about disease and treatment inclinations. Sympathy may advance patient self-efficacy. (10)

**Recommendations**

- Involve the modules of doctor-patient communication skills and clinical ethic in the curriculums of faculties of medicine and postgraduate councils of medical specialty.
- Encourage all hospitals and health centers to do academic activities, tutorials, and seminars in doctor-patient communication skills and clinical ethic for the best quality of care and outcome.
- Increase the numbers of doctors and referral clinics lead to the strengthening of doctor-patient communication skills, satisfaction, best clinical care and quality of health.

**Conclusion**

Doctor-patient communication skills were finished by therapeutic officials, recorders, doctors, and experts. They took a brief span 6-10 minutes for the restorative interview (74.3%), they didn't impart data to their associates in a similar unit by (46.5%) in 112 patients and didn't include other human services experts in patients' consideration by (62.7%) for 151 patients. Regardless of that the patients' fulfillment was (85.1%), while 36 (14.9%) of them aren't. Relational abilities are a specialty of medication and assume a significant job in building the specialist persistent relationship, arriving at
finding, fitting administration, great result, and further development.

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Ethical Approval: The study was approved by the Sudan Medical Specialization Board

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Appendices:
Annex:(1)

Assessment of Doctor-Patient Communication Skills OFTH June-November 2010

   d. Marital status: married single divorced widow

2/ Time of arrival…………………………
3/ Time of starting seen by medical personnel………………
4/ Time of leaving a doctor……………………………
5/ Seen by 1) MO… 2) R… 3) P …4) C….
Medical office, Registrar, Physician, Consultant
6/ Building Relationship:
   a. a warm greeting……b. listening attentively…. Eye contact…
   d. brief nonmedical interaction…….
7/ Doctor understanding the patient: a. Yes…. b. No……
8/ Doctor sharing information & ideas with 1. Pt: a. Yes…. b. No……
   2. colleague: a. Yes…. b. No…
9/ Doctor acknowledging social or emotional clues with empathy:
   a. Yes…..b. No……
10/ Doctor removing barrier/s: a. Yes……b. No……
11/ Doctor negotiates patient reaching agreement on:
   1. problem, a. Yes……b. No……
   2. plan&management, a. Yes…. b. No……
12/ Doctor providing closure:
   1. plan for follow-up a. Yes…. b. No……
   2. informing other health care professionals involved in the patient care a. Yes……b. No……
13/ Patient’s satisfaction. a. yes……b. No……. Why? if No……

Annex:(2)
Small Group Discussion; OFTH August-2010
Discussion with doctors in different units of medicine and surgery in order to assess their communication skills with their patients in OFTH August-2010

Elements of discussion:
- Definition of the title
- Objectives of the thesis
- How to communicate with your patient? (Open question)
- Do you know and follow any international framework or guideline?
- Did you follow all the steps of the framework?