Effective communication skills of medical staff and their relationship to the effectiveness of services provided to patients

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Abstract

Effective communication between medical staff and patients is a core determinant of healthcare quality, influencing patient satisfaction, adherence, safety, and clinical outcomes. This article synthesizes conceptual models and empirical evidence to examine how communication skills of physicians, nurses, and allied health professionals relate to the effectiveness of services provided to patients. Drawing on systematic reviews, experimental and observational studies, and measurement literature, we outline communication components (verbal, nonverbal, informational, relational), mechanisms by which communication affects outcomes, and the evidence linking communication skills to service effectiveness across settings and populations. We also examine contextual and moderating factors (patient age, health literacy, organizational systems, inter-professional communication), practical strategies for training and assessment, and implementation considerations for embedding communication improvement into routine care. The review highlights consistent associations between better communication and higher patient satisfaction, improved adherence, more accurate diagnosis and shared decision-making, reduced adverse events, and better patient-centred outcomes—particularly among older adults and vulnerable groups. Finally, we propose a framework for practice improvement and research priorities to advance measurement, intervention design, and system-level adoption of communication best practices.

Keywords: physician–patient communication, nonverbal communication, patient satisfaction, service quality, health outcomes, interprofessional communication, older adults

1. Introduction

High-quality healthcare rests not only on technical competence and evidence-based interventions but also on the capacity of medical staff to communicate effectively with patients and colleagues. Communication mediates crucial clinical processes—eliciting the history, explaining diagnoses and options, negotiating treatment plans, monitoring adherence, and coordinating care across settings. Patients regularly report that feeling heard, receiving clear information, and being treated with empathy are central to their experience and to perceived quality of care (Abbasi-Moghaddam et al., 2019; Ferreira et al., 2023).

Conversely, communication failures are a common root cause of dissatisfaction, poor adherence, safety events, and avoidable readmissions.

This article reviews theoretical perspectives and empirical findings about communication skills of medical staff and their relationship to the effectiveness of services provided to patients. We integrate scholarship on verbal and nonverbal skills, patient-centred interviewing, interprofessional communication, and measurement approaches, and we synthesize evidence on service-level outcomes such as patient satisfaction, perceived service quality, clinical adherence, rehabilitation and functional recovery, and patient-centred outcomes—paying special attention to older adults and those with limited health literacy. The goal is to provide clinicians, educators, managers and researchers with a concise, evidence-informed foundation to prioritize communication as an essential quality domain and to implement effective strategies for improvement.

2. Conceptualizing communication and service effectiveness

2.1 Communication domains

Contemporary frameworks distinguish multiple interrelated domains of healthcare communication:

- Relational/affective: empathy, warmth, respect, trust-building. These are conveyed through tone, attending behaviours and nonverbal cues and underpin therapeutic alliance (Berman & Chutka, 2016; Van Servellen, 2009).
- Informational/cognitive: clarity, completeness, tailoring of medical information, checking understanding, use of teach-back and decision aids. This domain supports comprehension and informed consent (Ferreira et al., 2023).
- Interviewing/elicitation: open-ended questioning, active listening, allowing adequate wait-time, eliciting patient concerns and context-specific factors (Berman & Chutka, 2016).
- Nonverbal: eye contact, touch, facial expression, body orientation, proxemics—all of which modulate perceived empathy and engagement (Butts, 2001; Sharkiya, 2023).
- Transactional/process: agenda setting, time management, efficient signposting, and closure that structure encounters and set expectations (Berman & Chutka, 2016).
- Interprofessional: structured handoffs, clear documentation, collaborative language and shared mental models among healthcare providers (Ifrim et al., 2022).

2.2 Service effectiveness outcomes

We define service effectiveness broadly to include patient-reported and system outcomes influenced by communication:

- Patient satisfaction and perceived service quality (Ferreira et al., 2023; Abbasi-Moghaddam et al., 2019).
- Adherence to treatments and preventative behaviours (Manzoor et al., 2019).
- Clinical outcomes and symptom trajectories (e.g., control of chronic disease, functional recovery).
- Safety outcomes: medication errors, adverse events, diagnostic accuracy (Ifrim et al., 2022).
- Health literacy, self-management capacity and earlier recognition of deterioration.
- Utilization outcomes: re-presentations, readmissions, appropriate follow-up (Sharkiya, 2023).

2.3 Mechanisms linking communication to effectiveness

Communication affects service effectiveness through multiple mechanisms: it improves elicitation of accurate history and risk factors (leading to correct diagnosis), increases patient understanding of treatment rationale and instructions (improving adherence), fosters trust and psychological support (reducing anxiety and facilitating engagement), and enhances coordination across providers (reducing information gaps and errors). Nonverbal cues amplify relational connection and can signal caring even when words are limited (Berman & Chutka, 2016; Sharkiya, 2023).

3. Evidence linking staff communication skills to service effectiveness

3.1 Patient satisfaction and perceived service quality

A robust body of evidence shows that better clinician communication is strongly associated with higher patient satisfaction and perceived service quality. Systematic bibliometric reviews find communication, medical care and waiting time among the top determinants of satisfaction (Ferreira et al., 2023). Abbasi-Moghaddam et al. (2019) reported physician consultation quality as the highest-scored outpatient service dimension; patients rated information disclosure and physician interaction as central determinants of perceived quality. Marzo et al. (2021) found that service quality provided by healthcare centers and physicians predicted patient satisfaction across settings; interpersonal competence was a key contributor. Manzoor et al. (2019) also reported that physician behaviour moderates the relationship between service provision and satisfaction, implying that the same clinical service yields different satisfaction when physician communication varies.

3.2 Clinical adherence and behavioural outcomes

Communication that is clear, tailored, and uses teach-back has been associated with greater adherence to medication and behaviour change. Manzoor et al. (2019) demonstrated that physician behaviour moderates how patients translate services into satisfaction and intention to adhere. For older adults in particular, Sharkiya's rapid review (2023) found that structured verbal and telephone-based communication interventions can improve self-management behaviours (e.g., smoking cessation in COPD), suggesting direct behavioural effects.

3.3 Patient-centred outcomes and wellbeing

Experimental evidence, though limited, indicates that nonverbal communication such as comforting touch can positively influence self-esteem, life satisfaction and perceived health among institutionalized elderly women (Butts, 2001 as reviewed by Sharkiya, 2023). Qualitative and observational studies of nonverbal and interpersonal strategies in nursing homes and long-term care show that active listening, eye contact, and respectful touch are associated with improved emotional wellbeing, perceived individualized care and adherence (Carpiac-Claver & Levy-Storms, 2007; Levy-Storms et al., 2011).

3.4 Diagnostic accuracy, safety and outcomes

While direct randomized evidence is sparse, communication failures are a recognized root cause in many safety reports. Properly elicited histories and patient cues—enabled by patient-centred interviewing—improve diagnostic sensitivity and can prevent missed or delayed diagnoses (Berman & Chutka, 2016). Interprofessional communication—structured handoffs and standardized documentation—reduces handover errors and adverse events (Ifrim et al., 2022). The JBI best-practice implementation project synthesized evidence supporting structured communication tools (SBAR, checklists) to improve inter-provider clarity and reduce information loss.

3.5 Service efficiency and utilization

Better communication that clarifies care plans and follow-up reduces unnecessary re-presentations and improves adherence to scheduled care. Abbasi-Moghaddam et al. (2019) found waiting time negatively correlated with perceived quality; communication that manages expectations and arranges timely follow-up mitigates dissatisfaction and inefficient reuse of ED services.

4. Special populations and contextual moderators

4.1 Older adults

Older patients often face sensory, cognitive, and social vulnerabilities that make communication more challenging and more consequential (Sharkiya, 2023). Studies show that tailored strategies—slower pace, larger print, teach-back, use of visual stories for limited health literacy, and telephone health-mentoring—improve outcomes among older adults (van 't Jagt et al., 2016; Walters et al., 2012). Bite-sized education tuned to sensory and cognitive capacity is particularly effective.

4.2 Health literacy and cultural/linguistic diversity

Patients with limited health literacy or language differences are at higher risk of misunderstandings, poor adherence and lower satisfaction. Using plain language, interpreters, pictorial aids, and teach-back reduces errors and improves perceived quality (Van Servellen, 2009; Ferreira et al., 2023). Participatory development of communication materials (photo stories) yields tools better matched to patients' needs (van 't Jagt et al., 2016).

4.3 Interprofessional context

Interprofessional communication—between physicians, nurses, allied professionals and across transitions (hospital to community)—is essential for continuity. Ifrim et al. (2022) emphasize best practices (standardized communication tools, shared documentation, role clarity) to ensure that allied-health inputs are transmitted to primary care and incorporated into follow-up plans, countering the common omission of allied-health recommendations in discharge summaries (Sheehan et al., 2021).

5. Measurement and assessment of communication competence .1 Patient-reported measures

Satisfaction and perceived communication quality are commonly measured via validated questionnaires; Ferreira et al. (2023) review shows widespread use of instruments like SERVQUAL and other tailored patient surveys. These capture patients' perspective on clarity, courtesy, information provision and accessibility.

5.2 Observer-rated and simulated assessments
Rubrics and structured observational tools (e.g., the Mayo Clinic interview rubric described by Berman & Chutka, 2016) enable formative assessment of specific communication behaviours—introduction, eye contact, active listening, organization, empathy and closure. Standardized patient encounters and OSCEs with checklists provide objective feedback for learners.

5.3 Process and outcome metrics
Service quality measures (wait times, admission processes, readmissions, adverse events) and clinical outcomes (control of chronic disease markers, functional recovery) are useful distal indicators of communication effectiveness when combined with process measures (completion of teach-back, documentation of shared decision-making, presence of tailored education).

6. Training and interventions to improve communication
6.1 Educational approaches
Communication skills can be taught and refined. Active learning modalities—role play, standardized patients, video feedback, reflective practice and interprofessional simulations—are particularly effective (Berman & Chutka, 2016; Van Servellen, 2009). Longitudinal reinforcement through clinical rotations and faculty modelling consolidates skills.

6.2 Focused techniques with evidence
- Teach-back: checking patient understanding by asking them to repeat information—improves comprehension and adherence.
- Agenda setting and open-ended questioning: elicit patient concerns and priorities, improving diagnostic yield.
- Empathy training and reflective exercises: enhance relational competence.
- Nonverbal awareness: training to use eye contact, appropriate touch, posture to convey warmth (Sharkiya, 2023).
- Structured communication across teams (SBAR, checklists) to improve handovers (Ifrim et al., 2022)

6.3 System-level supports
Embedding communication improvement into quality programs (performance metrics, feedback, protected training time), EHR design to prompt documentation of educational and allied-health inputs, and integrating interpreters and visual aids into workflows enhance scalability (Ifrim et al., 2022; Ferreira et al., 2023).

7. Implementation challenges and solutions
7.1 Time pressure and clinician workload
Clinicians often cite time constraints as a barrier to patient-centred interviews. Addressing this requires workflow redesign (longer visits for complex patients), team-based care (delegating education to trained nurses or health coaches), and training in efficient communication techniques (agenda setting, focused open questions) that do not substantially lengthen encounters (Berman & Chutka, 2016).

7.2 Measurement complexity and attribution
Attributing downstream clinical outcomes to communication interventions is challenging due to multiple confounders. Mixed-methods evaluations combining objective process metrics (e.g., teach-back rates), patient-reported measures, and qualitative data can elucidate mechanisms and contextual moderators.

7.3 Cultural and organizational alignment
Organizations must prioritize communication improvement as a strategic quality domain; leadership endorsement, clinician champions, and patient involvement in co-design strengthen adoption (Ifrim et al., 2022; Ferreira et al., 2023).

8. Practical recommendations for clinicians and managers For clinicians:
- Use patient-centred interviewing: start with open questions, allow uninterrupted narrative, then probe with focused questions.
- Practice active listening: maintain appropriate eye contact, allow silence/wait-time, summarize and use teach-back.
- Tailor information to health literacy and sensory needs; use visual aids and repeat key messages.
- Be mindful of nonverbal cues—posture, touch, tone—and seek permission before touch.

- Close visits with clear, prioritized plan and confirm understanding and follow-up.

For managers and educators:

- Implement structured communication training (simulations, rubrics) with feedback loops (Berman & Chutka rubric).
- Integrate measurement of communication into quality dashboards (patient surveys, observed behaviours).
- Support interprofessional communication using standardized tools and ensure allied-health inputs are included in discharge summaries (Ifrim et al., 2022; Sheehan et al., 2021).
- Allocate time and resources for communication improvement and incentivize participation.

9. Research gaps and future directions

Despite consistent associations between communication and satisfaction, gaps remain:

- Need for rigorous randomized trials of communication interventions with objective clinical endpoints and effect size estimates—particularly among older adults and high-risk populations (Sharkiya, 2023).
- Comparative effectiveness studies of different training modalities (simulation vs. in-clinic coaching) and of bundled interventions combining clinician skills, patient materials and system changes.
- Research on interprofessional communication interventions that explicitly include allied-health documentation and its impact on continuity and rehabilitation outcomes.
- Development and validation of pragmatic process measures (teach-back completion, documented shared decision-making) that can be operationalized in EHRs for large-scale evaluation.

10. Conclusion

Communication skills of medical staff are indispensable to the effectiveness of services provided to patients. Empathy, active listening, clear information exchange, and coordinated interprofessional communication consistently relate to higher patient satisfaction, improved adherence, better patient-centred outcomes, and enhanced safety. While evidence is strong for associations, the field needs high-quality intervention trials and scalable evaluation methods to quantify effects on clinical outcomes and to guide implementation at scale. Meanwhile, practical steps—training using validated rubrics, implementing teach-back and structured handoffs, tailoring communication for older adults and low-literacy patients, and embedding communication metrics into quality programs—can improve care today. Communication is not ancillary to clinical skill; it is an essential clinical competence that, when mastered and supported by systems, materially improves the value and effectiveness of healthcare services.

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