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Communication training: Skills and beyond

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ABSTRACT

Objectives: As communication is a central part of every interpersonal meeting within healthcare and research reveals several benefits of effective communication, we need to teach students and practitioners how to communicate with patients and with colleagues. This paper reflects on what and how to teach.
Methods: In the previous century two major changes occurred: clinical relationship between doctor and patient became important and patients became partners in care. Clinicians experienced that outcome and especially compliance was influenced by the relational aspect and in particular by the communicative skills of the physician. This paper reflects on teaching and defines problems. It gives some implications for the future.
Results: Although communication skills training is reinforced in most curricula all over the word, huge implementation problems arise; most of the time a coherent framework is lacking, training is limited in time, not integrated in the curriculum and scarcely contextualized, often no formal training nor teaching strategies are defined. Moreover evidence on communication skills training is scarce or contradictory.
Conclusions: Knowing when, what, how can be seen as an essential part of skills training. But students need to be taught to reflect on every behavior during every medical consultation.
Practice implications: Three major implications can be helpful to overcome the problems in communication training. First research and education on healthcare issues need to go hand in hand. Second, students as well as healthcare professionals need a toolkit of basic skills to give them the opportunity not only to tackle basic and serious problems, but to incorporate these skills and to be able to use them in a personal and creative way. Third, personal reflection on own communicative actions and dealing with interdisciplinary topics is a core business of medical communication and training.

1. Introduction

This paper is based on the keynote lecture given at the AACH conference in Montréal October 1 2013.

Communication is a central part of every interpersonal meeting within healthcare. As research reveals that effective communication is connected with satisfaction, compliance and to some extend with medical outcomes it is widely acknowledged that we need to teach students and practitioners how to communicate with patients and with colleagues. This paper reflects on what and how to teach.

2. What to teach

2.1. Brief historical perspective and comments

Thoughts on communicating with patients are not new, there are as old as medicine. Hippocrates, in fact, had some quotes on communication. He said: *"The patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician"* [1]. A strong sentence intuitively referring to the healing aspects of the doctor patient relationship.

In the mid 50s of the previous century huge criticism to the biomedical model came apparent and the psycho-biomedical model was born. Balint groups, with as most important aim support of doctors in their demanding task to deal with biomedical and psychosocial problems of patients, were installed [2]. The quote of Engel in 1998 is in that perspective well known: "*patients need to know and understand and feel known and understood*" [3].

Moreover patients became partners in care; they no longer passively had to undergo the treatment. They got the right to be informed, to ask questions, to deal with their own disease and even to decide together with the doctor about the treatment. In some countries like Belgium and the Netherlands, this right got a legal format as it became one of the topics in the 'law on patients' rights' [4,5]. In the US, the Health Insurance Portability Accountability Act HIPAA (1996) is intended to protect patients' medical records.

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It is important to notice that these principles are rooted in humanity and in the belief that good communication leads to more autonomy of the patient. Patient-centred communication puts these values at its centre.

In the same period research on communicative aspects of the medical consultation has been started and as a result the above described ideology of patient autonomy was picked up politically all over the world. The most important were, the statement of the American Medical Colleges in 1984 [6], of the Canadian Medical schools in 1992 [7] and the international consensus statement in 1999 about communication teaching and assessment in medical education [8]. All these statements have several issues in common: they all see doctor patient communication as an integral component of quality medical care; they highlight the need for formal training programs at the undergraduate, postgraduate and continuing education levels. They all state that teaching strategies can be defined to significantly change students' communication knowledge, skills and attitudes. Moreover the consensus statement in 1999, in Amsterdam at the conference of what later became the European association for communication in healthcare (EACH), completed the previous statements with the following advices: communication skills teaching should be planned and a coherent framework should be made; teaching skills and clinical teaching should be consistent and complementary; teaching communication should foster personal and professional growth; students' communication skills should be assessed as well as the teaching program should be evaluated; faculty development should be supported and adequately resourced [8].

2.2. Problems to be solved

Although a lot of effort has been made by countries all over the world, we are far away from these important advices. The implementation of communication training in medical schools has encountered a number of problems. The training mostly addresses specific items/topics like breaking bad news, genetic counseling, handling psychosocial problems or stop-smoking advice, but a coherent framework is lacking. Moreover training is often limited in time, not integrated in the curriculum and scarcely contextualized; no formal training or teaching strategies are defined. On the contrary the didactical techniques are often not adapted to the nature of the subject: ex-cathedra lectures on communication can teach the students that communication is useful and necessary but is not solely suited to confront them with their own communicative behavior or to help them to incorporate new communicative techniques in their consultation style. Students' communication skills are rarely reinforced when they enter the hospital for clerkships. Hospital care is diagnosis oriented, doctor centred and often related to acute interventions. Students are seldom stimulated to look for patient's ideas, concerns and emotions at the bedside [9]. And although the advice is given that formal training programs have to be installed not only at the undergraduate, but at postgraduate and continuing education levels as well, research shows that these programs often suffer from the same problems as described above, didactical principles are badly defined, assessment is seldom reported and the content is not always transparent [10].

In this broad field, there is little connection between research, teaching and implementation in practice for the benefit of the patient.

The problems described above stayed of course not unremarked. Warnings and advices were given by several authors at the end of the previous century and later on. Cegala pointed at the low priority for theoretical frameworks in communication research [11]. He stated that communication theory is essential for communication skills training to be effective.

Beckman and Frankel stated that theory might diverge from day to day reality, pointing at transfer from what is learned to how to behave in practice [12]. Makoul stressed the importance of the interplay between research and teaching, by saying: '*Research on patient–provider communication is most useful and necessary when it recognizes the importance of clinical work, can be translated into practice, and incorporates outcome measures such as clinical endpoints, provider and/or patient perceptions, behavior as adherence, quality of care, and practice patterns*' [13].

Education will only be valuable if linked to the daily practice of health care providers. Moreover teaching must draw on evidence, both on content and process of communication. Frameworks used for teaching and assessing communication skills need to be studied, to determine reliability and validity, and to gauge their feasibility in real-life practice. So there is the need for evidence in medical communication, a model of goals and functions need to be clear, and we need to think about theory and outcomes. Only then communication research and training will be in the attention of polity makers in different countries. But the most and ultimate reason is to improve the health and the lives of patients.

2.3. Evidence on 'what to teach'

Although the research field is rapidly growing and as a result the body of evidence on communicative issues in healthcare is increasing, the evidence remains limited.

First, communication has been and still is used as a container concept; this concept became so overwhelming that almost everything fits into and relates to communication. The quote 'without communication no medicine' is a nice illustration. The concept 'communication' definitively needs to be disentangled. Second, we have a variety of endpoints, without justification or priority. Some research reveals contradictory results like a positive effect of a patient centred intervention on satisfaction on the one hand and at the same time a negative effect on medical outcome parameters [14]. Until now it is not clear how to evaluate these outcomes. And of course this has huge consequences for communication training, what do we need to train if we know that positive and satisfying communication skills may hamper or negatively influence the medical health outcomes [15]. Another problem may occur if the intended communicative behavior like posing open questions e.g. is not connected to the improvement of patient outcomes due to the fact that the content of that open question is unrelated to the important issues in the eyes of the patient.

Third, what do we know about short and long term endpoints? e.g. if we study communication in relation to breaking bad news, do we look at reactions shortly after the consultation, like anxiety, or do we have attention for the quality of life of the patient and the next of kin during the whole period of disease, including death? As De Haes et all stated we need to define the goals of medical communication training [15].

3. How to teach

3.1. Effectiveness of training

Looking at how, the most important problem to face is the effectiveness of training and teaching. Two recent papers, by Veldhuijzen et al. and by Van Den Eertwegh et al., address these problems [16,17]. They give a summary of gaps and challenges within communication training. In their view the most important are: how to assess the effectiveness of training; how to deal with the context and the transfer of the training into practice; how to systematically implement the skills at organizational level.