



Healthcare Education

Improving patient-centered communication: Results of a randomized controlled trial



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ABSTRACT

Objective: Patient-centered communication is a key element for improving the quality of care in terms of therapeutic relationship, patient participation, and treatment process. Postgraduate trainings provide an essential way of promoting patient centeredness on the job where learning opportunities are often limited by time, patient volume, and economic pressure.

In the present study, changes in patient centeredness during clinical routines of postgraduate physicians (internal medicine) after a three-day communication training were assessed.

Methods: A randomized controlled trial was conducted in a primary care clinic. The intervention consisted of a communication training that aimed to enhance patient centeredness in postgraduate physicians. The training was based on a need assessment and the principles of deliberate practice. Workplace-based assessment of physicians' communication behavior was obtained using the Roter Interaction Analysis System.

Results: Three months after the intervention, trained physicians showed significantly increased patient centeredness ($F = 5.36$, $p = .04$; $d = 0.42$).

Conclusion: The communication training significantly improved patient centeredness during routine clinical practice. Thus, this training provides a structured and theory-based concept to foster patient centeredness.

Practice implications: The results support the implementation of communication trainings as a part of faculty development and medical specialization training.

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1. Introduction

Communication between physicians and patients is a key element of medical care, which is essential for anamnesis, diagnosis, informing patients about interventions, treatment planning, and outcome [1–3]. The characteristics of successful communication skills include creating a sustainable relationship, exploring patients' perspective, verbalizing emotional experiences, empathy, shared task-finding, and joint strategy development

[4–7]. These characteristics can be described as being “patient centered.” Studies have shown that patient-centered communication improves the working relationship, diagnosis, patient cooperation, and treatment outcome [8,9]. Furthermore, it is associated with increased patient satisfaction [4,10] and reduced medical expenses [11]. In contrast, poor communication can lead to limited patient adherence and can compromise trust in the physician-patient relationship [12,13].

Typically, patient-centered communication provides the conceptual basis of medical communication trainings [14,15]. Although these trainings are very heterogeneous [16], there is growing consensus on the structural and content features, which appear to be promising. Positive effects seem to particularly result from multi-day trainings with a high proportion of practical content (e.g., video feedback, role play with or without simulated patients) [17–19]. Among the discrete conversation techniques used in training, the WEMS technique (Waiting, Echoing,

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Mirroring, Summarizing) and the NURSE model for dealing with emotions (Naming, Understanding, Respecting, Supporting, Exploring) appear to be effective [20–23]. Recent publications have highlighted the value of structured and deliberate practice, ensuring that trainings result in long-term learning [24,25]. The opportunity to repeatedly practice basic skills and refine new behaviors outside high-pressure situations in combination with elaborate feedback seems to be crucial for successful learning [25,26]. In addition, how the training contents are embedded within practice-related context and connected to the needs of the target group is relevant [27–29].

In general, recent educational research has argued in favor of communication trainings for physicians in all training phases [30,31]. However, the value of these trainings has also been criticized. A recent study found a training-induced enhancement of end-of-life communication skills immediately after training; however, this effect did not transfer to subsequent patient interactions [32]. Furthermore, a review by Smith et al. [33] reported that only a few randomized controlled studies directly examined the *interventional* effects of patient-centered communication trainings as compared to receiving no training. In particular, there is less evidence regarding the effects of communication skills trainings for *postgraduate* physicians compared to undergraduates, and studies have reported mixed results [17,19,34,35]. Moreover, most studies with postgraduate physicians have been conducted in specific contexts (primary medical care or oncology) [36–40] or were tailored to specific communication events (e.g., breaking bad news [20,41–43] or teamwork training [44]). Whether patient-centered communication trainings are effective on a more general level, that is, within the broader context of everyday hospital routines, has hardly been investigated yet (see Ref. [45–47] for few exceptions). In contrast to communication in specific, challenging contexts (e.g., breaking bad news situations), physicians may be more likely to believe that their communication skills during ward routines are already highly adequate. Accordingly, they may be less motivated to get trained and thus be less likely to improve their communication behavior within these everyday contexts. Taken together, it remains unclear whether training-induced improvements of communication skills would also apply to communication events that occur during everyday hospital routines.

The present study sought to address this question. In particular, we aimed to investigate whether a training-induced improvement of patient-centered communication behavior could be demonstrated in a sample of experienced, postgraduate physicians during hospital routines. To meet the diverse communication demands in this rather generalized environment, a prior needs assessment was conducted. In particular, we developed a 3-day structured communication skills training for postgraduate physicians, which was based upon the theoretical framework of deliberate practice [24]. Furthermore, it comprised established training components (e.g., video feedback and role play) [17,19,22,46] tailored to challenging communicative contents in hospital routines as identified via the preceding needs assessment. Communication behavior of trained and untrained physicians was compared before and three months after training using a workplace-based video assessment of patient consultations.

2. Methods

2.1. Study design

The study was designed as a randomized controlled trial (RCT) including an intervention group and a waiting control group (Fig. 1).

The study was conducted in cooperation with the management board and the medical directors of three departments of internal medicine at a primary care clinic from September 2008 to March 2009. Physicians employed in these departments participated in the study and were exempted from work duties during the intervention. The study was approved by the ethics committee for Medical Research Ethics of the Landesärztekammer Baden-Württemberg and the ethics board of the cooperating clinic.

Physicians were randomly assigned to the intervention group or the waiting control group using stratified randomization. In particular, the randomization method was a matched pairs design as a special case of randomized block design. Pairs of physicians were generated that were matched for years of professional experience and demographic characteristics (gender, age). With regard to age and professional experience, the physician with the nearest values was chosen if there was no exact match. If more than one match was identified, pairs were assigned by drawing lots. Then, within each pair, the physicians were tagged either A or B by drawing lots. Physicians tagged as A were assigned to the intervention group and those tagged as B were assigned to the control group. The lists of physician pairs were created using Microsoft excel. Drawing lots was performed manually.

Data collection took place before and three months after the intervention. The three-month delay was chosen to capture the actual transfer of behavioral changes to the workplace as opposed to short-term reproductions of trained behavior. At each time point, five patient consultations of each physician were videotaped. These patient consultations took place during ward routines and covered the whole range of clinical conversation (e.g., admission, ward rounds) and different explicit goals (e.g., explaining diagnostic findings, preparing discharge). Patients were blinded to the group membership of the consulting physician (intervention vs. control group) and to the time of recording (before vs. after intervention).

Before the beginning of the study, all participants were informed about the study design and basic demographic data including prior training experience was collected. The following measures were realized to protect against contamination between intervention and control group: all physicians were instructed to perform “as usual” during videotaped conversations and were asked not to participate in educational activities related to patient-centered communication during the study. In addition, physicians in the intervention group were specifically asked not to discuss training contents or study-related information with physicians in the control group. Prior to data collection, two focus groups comprising volunteering physicians from the study sample discussed self-perceived difficulties and learning needs regarding communication skills. The results of this needs assessment were incorporated into the training (see Section 2.3).

Once the study was completed, physicians in the control group received equivalent communication training.

2.2. Inclusion criteria

Physicians

Participation in the study was mandatory for all senior physicians and residents employed at the departments of internal medicine. Two physicians were excluded because they had previously completed communication training similar to parts of the intervention. The remaining 42 physicians had no prior training in communication behavior or patient-centered medicine. Participants provided written informed consent following a detailed explanation of study goals, time-line, and content.

Patients

For both data collections, patients were recruited as an ad hoc sample. They were asked to participate when they were available

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