



Communication Study

Working alliance in communication skills training for oncology clinicians: A controlled trial

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ABSTRACT

Objective: The aim of this study was to evaluate the impact of communication skills training (CST) on working alliance and to identify specific communicational elements related to working alliance.

Methods: Pre- and post-training simulated patient interviews (6-month interval) of oncology physicians and nurses ($N = 56$) who benefited from CST were compared to two simulated patient interviews with a 6-month interval of oncology physicians and nurses ($N = 57$) who did not benefit from CST. The patient–clinician interaction was analyzed by means of the Roter Interaction Analysis System (RIAS). Alliance was measured by the Working Alliance Inventory – Short Revised Form.

Results: While working alliance did not improve with CST, generalized linear mixed effect models demonstrated that the quality of verbal communication was related to alliance. Positive talk and psychosocial counseling fostered alliance whereas negative talk, biomedical information and patient's questions diminished alliance.

Conclusion: Patient–clinician alliance is related to specific verbal communication behaviors.

Practice implications: Working alliance is a key element of patient–physician communication which deserves further investigation as a new marker and efficacy criterion of CST outcome.

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1. Introduction

1.1. Communication in cancer care

Communication has been recognized as a key element in medical and especially in cancer care, affecting both clinicians and patients [1,2]. Ineffective communication may result in patients' confusion [3,4], psychological distress and difficulties in expressing feelings and understanding information [4,5], and contribute to clinicians' stress, lack of job satisfaction and emotional burnout [6,7].

1.2. Communication skills training

These observations have led to the development and implementation of communication skills training (CST) for oncology clinicians [8]. Such training aims to increase the clinician's skills to respond to the patient's needs, to foster their relationship and to facilitate the exchange of information.

There is increasing evidence, that CST improves patient–physician communication [9–13]. For example, Fallowfield et al. [14] found that clinicians attending a 3-day CST use more focused and open questions, fewer leading questions, express more empathy, interrupt patients less often and provide more appropriate responses than those without training. It has also been demonstrated that CST enhances reassurance, recognition of emotions and understanding of the patient [15–17]; in addition, psychosocial issues and concerns are more often addressed [18–20], the interview is prolonged [21], verbal dominance is reduced [17] and patients participate more actively [16,18], in particular by asking more questions about their diagnosis [20]. However, CST has been criticized for overlooking the relational and affective dimensions of the patient encounter [22–24].

1.3. Alliance

In healthcare, the importance of the relational factor – described as the “connective dimension of medical care” [25] – has been recognized in the patient-centeredness theoretical and empirical literature. Patient-centered care promotes a physician–patient relationship in which psychosocial issues and the patient's illness experience are addressed and patient and physician share decisional responsibility [26]. Working alliance, broadly defined as the development of common agreed tasks and goals and a strong

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therapeutic bond, is seen as a fundamental requirement, not simply a useful addition to the medical model [27]. A sound conceptual framework and growing empirical evidence confirm the importance of working alliance in healthcare: moderate to strong relationships were found between working alliance and patient's perceived utility or value of treatment, patient's self-efficacy, treatment adherence, and satisfaction with community care [28–30].

Working alliance includes two elements: (1) at a fundamental level, the patient's ability to trust, hope and have faith in the clinician's ability to help, and (2) different types of alliance depending on the relevant therapeutic tasks and goals [31]. It refers to a collaborative and/or a negotiated relationship characterized by the patient's involvement in the treatment process. Strong alliance implies that (i) the clinician and the patient define the medical problem together, (ii) they agree on the objectives and (iii) jointly develop a treatment plan, (iv) for which they share responsibility. To build and strengthen working alliance, communication behaviors that enable clinicians to reinforce patient cooperation, like checking for his/her understanding, asking for his/her opinion, approving his/her point of view or reflecting his/her feelings are important. But it depends on patients' and therapists' characteristics. For example, if a patient is rather anxious and somehow overwhelmed by the situation, it might not be adequate to face him with open questions and to focus on his emotions, but more beneficial to give him the relevant information concerning the current situation and the therapeutic strategy. It also depends on the practitioners' institutional role, related to different tasks and goals. Salmon et al.'s study on cancer surgeons relationship [32] highlights the importance of the surgeons' expertise and character instead of emotional engagement for building an authentic caring relationship.

Working alliance has mainly been developed and investigated in psychotherapy. It has consistently been identified as the most robust predictor of outcome across different therapeutic approaches for a variety of patients [33]. Recent studies suggest that both, the therapist's skills and personal factors influence the working alliance with the patient; more specifically, the quality of communication skills [34,35], as well as the clinician's ability to convey understanding of the patient's phenomenological perspective [36,37] have been found to foster alliance. These results highlight the need for a better understanding of the interactive nature between technical (communicational skills) and relational (interpersonal skills) dimensions of clinical relationship [38]. The question of the validity of the concept of working alliance in the field of cancer care is an open question.

1.4. Objective and hypotheses

The aim of this study was to evaluate the impact of CST on working alliance and to identify specific communicational elements related to alliance for two professional groups, nurses and physicians. Three hypotheses were tested:

Change in the working alliance. Alliance will be enhanced by CST; alliance will be higher after training than in the control group.

Working alliance and verbal communication. The frequency of communication behaviors directly related to working alliance (more specifically 'building a relationship' and 'partnership building', see Section 2.3.2) will be related to the level of alliance.

Differences between physicians and nurses. As alliance is related to the institutional role, no differences in the level of alliance after training will be observed, but some specific communication behaviors (more biomedical communication for physician and more psychosocial communication for nurses).

2. Methods

The sample study was based on a pre–post controlled trial including oncology clinicians who participated in CST (CST group) and oncology clinicians who did not (CTRL group). The design and the procedure of the study have been extensively described elsewhere [22]. While a first analysis of the sample focused on clinicians' defense mechanisms, a second grant allowed to investigate alliance with the above mentioned aims.

2.1. Sample

One hundred and thirteen oncology physicians and nurses participated in the study. For the physicians of the CST group, the training was mandatory. For the CTRL group, oncology physicians and nurses were recruited on a voluntary basis (these physicians did not yet register for the CST). The group was formed after the CST group and matched according to profession, age and gender. The physicians and nurses of the CTRL group did not receive any specific CST during their professional career.

In the CST group ($N = 57$), 43 participants (75.4%) were women, 30 (52.6%) physicians and 27 (47.4%) nurses, and mean age was 37.9 (SD = 7.2). In the CTRL group ($N = 56$), 35 participants (62.5%) were women, 21 (37.5%) were physicians and 35 (62.5%) nurses, and mean age was 39.4 (SD = 9.3). The sociodemographic variables, such as years of professional experience, did not significantly differ between groups. The main physicians' and nurses' characteristics (gender, age and years of professional experiences) are listed in Table 1.

2.2. Study design

The CST consisted of a 2-day course, during which participants are trained by means of case-history discussions, structured role play and video analyses of simulated patient interviews, followed by 4–6 individual supervisions over the next 6 months and another half-day training session [1,2,11,22,39–42].

The CST used in this study is part of a national CST, which has been implemented over a decade ago [8]; meanwhile it has become mandatory [42] and it has been demonstrated that it enhances patient-centered communication [43,44] and it improves clinicians' emotional regulation [1,2,22]. Specific features of alliance were not part of the training, but the CST focuses on empathy, careful listening, openness to the patient's expression, shared decision making and interest in the patient's subjective and psychosocial experiences [42]. These elements are related to interpersonal skills, postulated to be key factors of alliance building.

Each participant conducted two 15-min video-taped interviews with simulated patients before and at the end of the CST. Short written instructions were provided to the clinicians and actors (simulated patients) prior to the interviews, specifying the type of cancer, the age of the patient, the type of treatment and the objectives of the interview. Participants of the CTRL group also conducted two 15-min video-taped interviews, separated by a 6-month interval, with the same simulated patients, the same

Table 1
Characteristics of the clinicians.

	Nurses		Physicians	
	M	SD	M	SD
Age	39.0	8.5	38.4	8.0
Gender (% women)	82.0		53.0	
Experience (years)	14.7	8.0	10.7	8.3

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