

FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: PERSON-CENTERED BASIC COMMUNICATION SKILLS

Best Evidence Teaching of Person-centred Basic Communication Skills: a reflection

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Abstract

Adequate person-centred communication is an important cornerstone of good clinical practice and therefore requires training, just like other aspects of medicine do. The exact content of person-centeredness can vary depending on specific context and culture, but key issues mentioned frequently are: providing room for the patient's story through involvement in consultations, with an emphasis on dialogue with the physician, exploring emotional cues and showing empathy, attention to the patient's context, adjusting information and advice to that context and framing it in a positive way and involving patients in decisions on the management of illness. In practice, however, the concept of person-centeredness some-times works out differently from the one 'on paper'.

During the Third Geneva Conference on Person-Centered Medicine, a case history was used for discussion with the audience about patient centeredness. The focus was gradually shifted from the content of person-centeredness to the principles of teaching/training of communication skills. The participants contributed their opinions and these were supplemented with the available evidence from the literature leading to the reflection in this article.

Keywords

Patient centeredness, Communication skills, Teaching, Medical education

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Introduction

This article discusses the outcome of an interactive presentation during the Third Geneva Conference on Person-Centered Medicine in 2010, involving the audience in a learner-centred way.

Adequate person-centred communication skills are important cornerstones of good clinical practice. If physicians (and other health care workers) lack these skills, patients as well as physicians are less satisfied, and health outcomes of patients are less positive [1,2].

To understand the many challenges of teaching person-centred communication skills, it is necessary to discuss the nature of person-centeredness first. Over time, many definitions of the terms patient and person-centeredness have been described in the literature. But the

concept, not always using the specific term, has been appearing, disappearing, reappearing and evolving in various places for a much longer time. As Moira Stewart points out in her Mackenzie Lecture, the concept can be traced back in the literature as far as Mackenzie, who lived and published in the 19th century, but perhaps even dates back as far as Hippocrates.[3] Paul Tournier from Switzerland described his views in his book *Médecine de la Personne* in 1939/40 and so did Dr. Buma from the Netherlands around the same time [4,5]. Later on, both Balint and Engel strongly supported the idea that medicine should not only be about biomedical science. They emphasized the importance of the person who experiences symptoms, discomfort or problems and his or her context and social environment and that the relationship of the physician with that person has an important influence on what happens during consultations. The principles of their

models are still used in practice and in medical education [6,7].

There is growing evidence, with many individual studies and reviews, showing that patient outcomes of person-centred consultations are better than those of doctor-centred consultations, although the evidence is not consistent (yet) [1,2,8-10].

Person and patient-centeredness

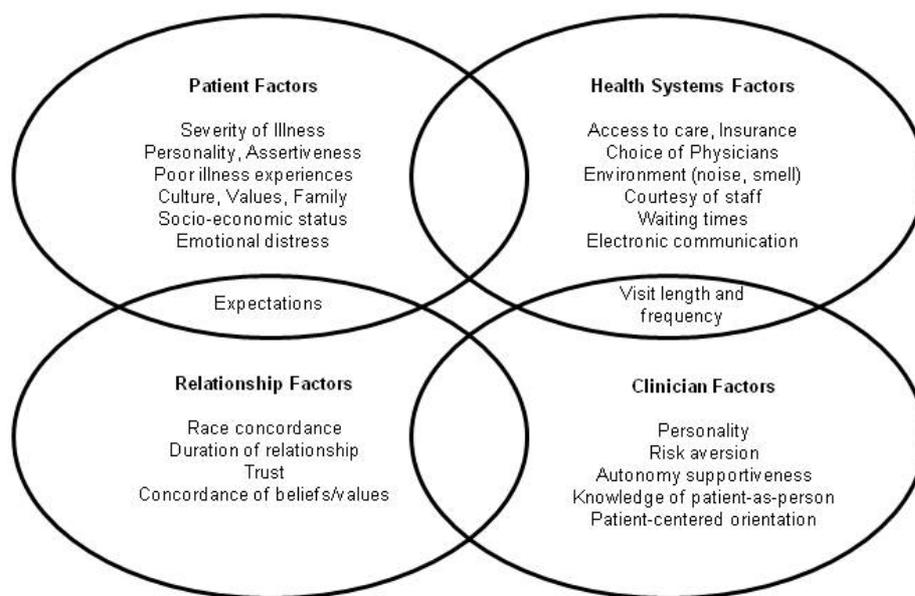
In the context of medicine, the terms person and patient-centeredness are often used interchangeably. In this article, because of the quoted, relevant literature and the context of medical education, we will use the term patient-centeredness.

The definition and content of patient-centeredness vary, but key issues mentioned frequently are: providing room for the patient's story through involvement in and beyond consultations; stressing the importance that a

patient is seen as a person; attention for context as well as the symptoms or problems of that person, taking into account social, psychological and biomedical factors; an emphasis on a dialogue between patient and health care provider; exploring emotional cues and showing empathy; adjusting information and advice to the person's context, and framing it in a positive way and involving patients in decisions on the management of their illness. However, the patient-physician relationship is not one-sided. Therefore, paying attention to the person of the doctor with an awareness of the influence of the doctor's personal qualities on the practice of medicine is also a component of patient-centeredness.

In their publication in *Social Science & Medicine* Epstein and associates discuss important factors influencing patient-centred communication [11]. Their figure (below) very clearly demonstrates why patient-centeredness varies by showing the interaction and overlap between the various factors and why always being patient-centred can be so difficult.

Figure 1. Factors influencing patient-centered communication



Examples

In the context of practice let us consider for instance, the typical case when there is a shortage of time or a large number of patients who all need to be seen urgently. What is person-centered care for the patient who gets most time and can elaborate on context issues might seem very person-centered for that individual, but is not for the next patient.

Another example which we discussed with the audience included consultations in which culture play a role. When the culture of the physician and patient do not match, and/or decisions have to be made and might be different from both cultural perspectives, problems are likely to arise.

Different cultural views on breaking bad news demonstrate the dilemma. In many Western countries with cultures emphasizing individual freedom and choice, full disclosure is common and described in guidelines as best

practice [12,13]. Every patient should be fully informed about his or her condition. In some countries, for instance in the Netherlands, patients have to be fully informed, by Law. But this is certainly not seen as best practice all over the world. For example, in South East Asia, where the society is more collectivistic and the family plays an important role in important decisions and choices in life. Non-disclosure might be more appropriate in some circumstances and should be negotiated carefully [14]. It is even more complicated for a physician living in a Western culture, to treat a patient from a collectivistic culture. Even though a person has a 'right to know', and if there is a law dictating the amount of information, physicians will have to make a person-centered choice every time, minimizing potential harm for that person, but within the context and culture of that person, who has to continue living in that reality.

These examples show that reading and writing about the concept on paper is not the same as always being person-centered in the reality of everyday, busy practice, with so many competing demands. And teaching of patient-centeredness therefore faces even more challenges.

Teaching of communication skills and educational methods

Even in less difficult circumstances and easier consultations, person-centred communication skills do not come naturally to all physicians. This has been an important reason for many medical schools to incorporate communication skills programs in their curricula in the past few decades. There is ample evidence that it is possible to teach and learn adequate (person-centered) communication skills to students, residents and practicing physicians and there is also evidence about what works best [15-19]. Methods using experiential learning seem best to transfer these skills. This means that a learner has the opportunity to experiment and practice him or herself (one to one). Using active small groups in a safe learning environment is also important. This can be realized in a number of ways, but key to success is that when learners practice they have to be observed and receive effective and focused feedback[20]. Use of Video/DVD or audio recording helps such feedback. As teaching methods, role play, simulated patients (SP's) and/or taping of consultations with real patients all have their advantages and can be used for observation and feedback and all these methods open up the opportunity to practice again after watching one self and/or receiving feedback from others [21].

Role play has the important advantage that learners can step into the role of patient as well as physician and in that way experience how it feels from 'both sides'. Even without giving feedback, this is an important and revealing experience. Practicing with simulated patients often feels

closer to the reality of clinical practice than role play, and they can be trained for their educational tasks and can be scheduled when needed. Lectures are not as effective in the learning of skills, although in combination with other methods, they do serve an important purpose. Even when transmitting knowledge, lectures are only effective if they are clear and well structured, interactive, used in combination with other teaching methods/discussions and relate to the learner's 'real life' problems and challenges. The difficulty with lectures is that the average attention span declines after 15-20 minutes, retention rate is low. It is only 5% - 10% for reading, but increases to 50 % for group discussions, which can be incorporated in lectures, but seldom are. It is also not possible to address individual needs of learners in a lecture and adjust the content to these needs, something that is very necessary with regard to person-centered communication skills [15,22,23].

Challenges

Clinical practice requires physicians who are clinically competent. This means they should be able to integrate knowledge, (person-centered) communication skills and other medical technical skills (physical examination and other procedures), but they should also have adequate problem-solving skills to integrate diagnostics and management as well. This poses medical curricula with a considerable challenge, because it would be best if curricula would take all the aspects influencing person-centred communication skills and all said above into account. Unfortunately, even though the subject gets attention, many curricula have isolated communication skills programmes. Communications skills and patient centeredness are taught and practised in separate courses and without integrating other aspects like medical knowledge and other skills in that same course and without alternating training with clinical practice.

It would be advisable for medical schools to develop and incorporate communication teaching throughout entire curricula rather than in separate courses. Indeed, reflection, deepening and broadening of patient-centred skills should have an important role throughout the *entire* curriculum. A communication curriculum should thus not be offered in isolation but integrated with basic medical education and communication skills. And it must, using the variety of patient populations and settings, pay full attention to culture. This does mean that feedback and reinforcement have to be given throughout the whole period of training and not just at the start of a curriculum before going into practice, as is now often the case.

In addition to training, the assessment of person-centred communication skills should be an integral part of every medical curriculum. As Silverman pointed out again during the European Association for Communication in Healthcare (EACH) conference in Oslo in 2008, assessment drives learning and assessment of

communication side-to-side with that of medical content is a strong message for learners. There are valid methods available with which to do this [24].

Conclusion and recommendations

It is possible and important to train current and future physicians and health care workers in patient-centred communication skills. Medical curricula should take into account the whole process of training, feedback and assessment and offer programmes in which these skills are integrated with other medical skills and with clinical practice. Furthermore, training of person-centeredness should be extended to residency and CME. During clinical practice it is difficult to remain person-centred in the setting of busy everyday clinical practice with little time per consultation and the focus on medical content. Practical obstacles exist and methods and systems need to be developed in attempts to overcome them.

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