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Editorial

Communication Skills: When, Not If, To Teach

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THE IMPORTANCE of sound doctor-patient communication skills is a modern-day shibboleth. Inadequate communication skills can reduce compliance with treatment, may lead to an inadequate, or even wrong, diagnosis and minimise the likelihood that psychosocial difficulties will be identified. These are the most common cause of complaints from patients, and increase the risk of litigation [1].

Effective communication in oncology is particularly important. Eighty women attending a Scottish gynaecological follow-up clinic were asked to indicate the most important characteristics of a good gynaecological oncologist. Ability to communicate with the patient was given first place by 39% of the women, and the ability to understand how the patient felt by 27% [2].

A growing literature testifies to the positive benefits of the right person, giving the right information, at the right time, in the right way and in the right place. In a study of women with gynaecological cancer, at follow-up, those with clinically significant anxiety or depression were those more critical of various aspects of doctor-patient communication at the time of diagnosis and during the first month of treatment. Most commonly, they felt that they had not been told enough, although a few patients considered that they had been told too much [3]. This, and other studies, indicate that meeting the information needs of patients who have cancer, and involving these patients, if they so wish, in making management decisions, can do much to promote quality of life and minimise the risk of psychiatric disorders [4, 5]. However, 5 years ago, a consensus conference identified numerous unanswered questions [6] and, unfortunately, many of these questions remain unanswered. From a practical point of view, there is a striking absence of empirical research to guide clinicians on the relevant psychosocial factors that should be taken into account in deciding how best to help individual patients and, of course, their families. Although a great deal has been written about how best to break bad news, as with giving other kinds of information, randomised trials are urgently required [7, 8].

If good communication skills receive the same approbation as motherhood and apple pie, the obvious questions are: can

these skills be taught; if so, how should they be taught; at what stage in a doctor's career should they be taught, and how should they be evaluated?

A substantial body of evidence now exists to show that, within limits, communication skills can be improved significantly with appropriate feedback and practice [9-11]. Various courses have been reported in detail [6, 12, 13]. However, there is a great need for further randomised studies to evaluate the various training methods that have been proposed (for example, feedback from patients, the use of simulated patients or relatives, rôle playing, group discussion, model interviews, and discussion of video recordings of interviews containing 'nodal points').

Surprisingly, with the exception of video feedback, little use has been made of technological advances. A notable exception is a study that was recently funded by the Scottish Council for Postgraduate Medical and Dental Education. The aim of the study is to evaluate the effects of an interactive digital video teaching programme in helping students to learn how to deal effectively and confidently with critical communication issues in relation to diagnosis, treatment and prognosis, and the results are awaited with great interest [14]. Whilst technology must always be the servant and never the master of educational development, advances in information technology open up new educational possibilities that need to be explored, developed and evaluated, as in this study.

As far as timing is concerned, communication skills can be taught during the undergraduate years, during postgraduate training, or once clinicians have achieved seniority. In this issue, Maguire and colleagues (pages 1486-1489) report on the effects of a workshop programme on the key interviewing skills of 169 health professionals (doctors, nurses, social workers and others). They interviewed simulated patients immediately before, and immediately after, the workshop, and again 6 months later. An utterance by utterance analysis indicated that the workshops increased the number of 'open directive' questions, questions with a psychological focus and clarification of psychological aspects (thereby promoting enhanced patient disclosure of key concerns). There was also a reduction in the use of questions with a physical focus and in giving advice prematurely. As a result of these behavioural changes, following the workshop, participants were able to identify

more of the key problems. As the authors point out, however, there was still room for improvement. Participants continued to worry about harming patients, and they felt that they needed more practical and emotional support. Whilst there were still significant improvements at 6 months follow-up, there had been some deterioration. This raises important issues about the maintenance of skills, the follow-up support required and the need for 'booster' sessions. This study, which is the latest in a series of valuable, systematic investigations by Maguire and colleagues, confirms that the communication skills of doctors and other health professionals can be significantly enhanced, even by relatively brief workshops.

One way of providing an environmental climate conducive to the maintenance and development of good communication skills is the 'top down' approach that has been pioneered by Fallowfield and her colleagues. They have held a number of residential workshops for senior oncology clinicians. Of 158 senior clinicians attending training courses on communication skills, less than 23% had previous experience of any form of such training [15]. These courses are a very exciting development and the detailed results will be of great interest to oncologists.

The importance of teaching communication skills to undergraduates has been highlighted by the U.K. General Medical Council in their most recent pronouncement (*Tomorrow's Doctors*) [16]. They note that "the relationship between doctor and patient has changed and there is a clear duty in the doctor to be able and willing to communicate effectively, an attribute that must be developed throughout the undergraduate course and beyond". The report continues "Doctors must be good listeners if they are to understand the problems of their patients and they must be able to provide advice and explanations that are comprehensible to patients and their relatives. Skill in communication is also at the heart of counselling". Sadly, some studies of undergraduates have shown that communication skills deteriorate during the clinical years [17, 18] although, encouragingly, there is good evidence that techniques such as video feedback can significantly enhance performance [9, 11].

Since the 1970s, an interview methods course has been compulsory for all undergraduates at The Aberdeen Medical School. Each third year medical student is required to make a video recording with a real patient and to receive feedback from a group of approximately 10 peers and two tutors (one of whom is a psychiatrist or clinical psychologist and the other a physician, surgeon or general practitioner). Within the context of this course, a randomised study was recently carried out to evaluate the possible advantages of using patients who have cancer. Half the students were taught with patients who had cancer (experimental group) and half were taught with other patients (control group). A number of immediate positive attitudinal changes were found in the experimental group [19]. Two years later, when in their final year, the students were reassessed. Compared with students in the control group, the students in the experimental group considered that communication skills were more important and they were more likely to consider that clinical decisions about treatment should take into account the patient's wishes. More importantly, when the video recordings that were repeated in the final year were rated, students in the experimental group were significantly more empathic, showed greater regard and concern for the patient, and were more likely to demonstrate a negotiating style, and to assess the impact of symptoms on

the patient's life [20]. These are encouraging results which confirm that important skills can be taught to medical students. They also suggest that the participation of patients with cancer may have particular advantages.

It is well known that the examination system plays an important part in determining what students consider to be important in the curriculum. It is essential, therefore, to examine communication skills and to insist on certain minimum standards before students are allowed to progress. In 1993, a fourth year degree examination in communication skills was introduced at Aberdeen. The examination has degree status; unless students pass the examination, they cannot progress to the final year. It might be argued that the assessment of communication skills is a rather subjective matter. However, in practice, there are a number of things that are axiomatic and on which all can agree: for example, doctors should never be rude or discourteous to patients, they should introduce themselves, pay attention to the patient's comfort, take steps to put the patient at ease, and they should listen attentively to what the patient says. In practice, it has not been difficult to agree on criteria or to ensure consistency. Examiners attend a training workshop where these matters are defined and discussed. The survey carried out by the U.K. General Medical Council in 1992 found that only seven schools included communication skills as a formal part of their final examinations [21]. This is nothing short of a disgraceful state of affairs. If students are to take communication skills seriously, these skills must be examined. Ideally, they should be examined by senior physicians and surgeons, using the patients of the examiners, thereby endorsing the importance of these skills, promoting generalisation across specialties and ensuring that students do not consider that communication skills are the preserve of the mental health disciplines.

It would be a mistake to restrict the teaching of communication skills to doctor-patient communication. Communicating effectively with the relatives of patients is no less important than communicating with the patients themselves. Harrison and colleagues [22] interviewed the relatives of 108 patients whose cancer had recently been diagnosed. They found that relatives had a significantly greater number of concerns than the patients, and showed a very high level of psychological distress and morbidity.

There are also cultural and subcultural considerations. In some countries, for example Greece, it is more common for the relatives rather than the patient to be told the diagnosis. In one Greek study, as few as 15% of the patients knew that they had cancer [23]. Only 51% were satisfied with the information they had been given. Interestingly, however, although 50% wanted to know more about their illness, 34% did not. Whilst some patients may have been diffident about expressing opinions that could be regarded as criticism (data were collected by interviewing), studies from North America and the U.K. have typically found that a much smaller proportion of patients did not wish to know the diagnosis or to receive further information [3]. An international collaborative study (Aberdeen, Scotland; Ioannina, Greece; Madrid, Spain) using a common protocol is currently underway to evaluate the differences in information given to patients, patient satisfaction with the information given, and other aspects of doctor-patient communication [24]. This study may provide valuable insights into the interplay between individual coping strategies, cultural expectations about doctor-patient com-

munication and the ability to cope with the diagnosis and treatment.

Good communication skills are not only important from the patient's point of view; they may be important in terms of preserving the mental health of oncologists. Inadequate communication skills can reduce job satisfaction, promote 'burn-out' and increase the risk of psychiatric problems. In a study of 393 oncologists in the U.K., only 56% considered that they had received adequate training in communication skills. Oncologists who considered this aspect of their training to have been inadequate reported lower levels of personal accomplishment and a greater use of depersonalisation (treating patients as objects) [25]. The development and evaluation of effective training programmes for communication skills may be a vital factor, therefore, in protecting oncologists, young and not so young, as well as their patients, from the untoward consequences of work-induced stress.

1. Ley P. *Communication with Patients: Improving Communication, Satisfaction and Compliance*. London, Chapman and Hall, 1990.
2. Smith C, Kitchener HK, Walker LG. A study of the attitudes of Scottish women to female cancers. Behavioural Oncology Unit, University of Aberdeen, U.K., unpublished manuscript.
3. Paraskevaidis E, Kitchener HC, Walker LG. Doctor-patient communication and subsequent mental health in women with gynaecological cancer. *Psycho-Oncology* 1993, 2, 195-200.
4. Fallowfield LJ, Hall A, Maguire P, et al. Psychological effects of being offered choice of surgery for breast cancer. *Br Med J* 1994, 309, 448.
5. Richards MA, Ramirez AJ, Degner LT, et al. Offering choice of treatment of patients with cancers: a review based on a symposium held at the 10th Annual Conference of the British Psychosocial Oncology Group, December 1993. *Eur J Cancer* 1995, 31A, 112-116.
6. Simpson M, Buckman R, Stewart M, et al. Doctor-patient communication: the Toronto consensus statement. *Br Med J* 1991, 303, 1385-1387.
7. Buckman R. *How to Break Bad News: A Guide to Health Care Professionals*. Baltimore, The Johns Hopkins University Press, 1992.
8. Girgis A, Sanson-Fisher RW. Breaking bad news: consensus guidelines for medical practitioners. *J Clin Oncol* 1995, 13, 2449-2456.
9. Lipkin M, Quill TE, Napedano RJ. The medical interview: a core curriculum. *Ann Intern Med* 1984, 100, 277-284.
10. Maguire P, Fairbairn S, Fletcher C. Consultation skills of young doctors: benefits of feedback training in interviewing as students persist. *Br Med J* 1986, 292, 1573-1576 (correction in *Br Med J* 1986, 293, 26).
11. Wakeford R. Communication skills training in UK medical schools: a discussion of the present situation and the obstacles to innovation and change in undergraduate medical education. In Pendleton D, Hasler J, eds. *Doctor-Patient Communication*. London, Academic Press, 1983.
12. McManus IC, Vincent CA, Thom S, et al. Teaching communication skills to clinical students. *Br Med J* 1993, 306, 1322-1327.
13. Lovett LM, Cox A, Abou-Saleh M. Teaching psychiatric interview skills to medical students. *Med Educ* 1990, 24, 243-250.
14. Alexander DA, Klein S. *Medical Undergraduate Teaching of Critical Communication Issues by Means of Conventional Methods and Interactive Digital Video: A Controlled Postgraduate Follow-up*. Edinburgh, Scottish Council for Postgraduate Medical and Dental Education, 1996.
15. Fallowfield L. Can we improve the professional and personal fulfilment of doctors in cancer medicine? *Br J Cancer* 1995, 71, 1132-1133.
16. General Medical Council. *Tomorrow's Doctors: Recommendations on Undergraduate Medical Education*. General Medical Council, December 1993.
17. Maguire RP, Rutter DR. Consultation skills of young doctors: I. Benefits of feedback training in interviewing as students persist. *Br Med J* 1986, 292, 1537-1538.
18. Helfer RE. An objective comparison of the interviewing skills of freshmen and senior medical students. *Paediatrics* 1970, 45, 623-627.
19. Klein S, Kitchener HC, Walker LG. Does cancer patient participation in communication skills training enhance the performance of medical undergraduates? *Psycho-Oncology* 1995, 4, 90.
20. Klein S, Kitchener HC, Tracy D, Walker LG. Does cancer patient participation facilitate communication skills training in medical undergraduates, and do the effects persist? *Manuscript in preparation*.
21. General Medical Council. *Commentary on the Second Survey of Medical Education Practices in United Kingdom Medical Schools*. London, General Medical Council, 1992.
22. Harrison J, Haddad P, Maguire P. The impact of cancer on key relatives: a comparison of relative and patient concerns. *Eur J Cancer* 1995, 31A, 1736-1740.
23. Lavrentiadis G, Manos N, Christakis J, Semoglov L. The Greek patient's knowledge and attitudes towards his diagnosis and prognosis. *Psychother Psychosom* 1988, 49, 171-178.
24. Pardo R, Galvez R, Palomo T, et al. Doctor-patient communication and patient satisfaction in cancer patients: joint Aberdeen-Ioannina-Madrid protocol. *Proceedings 10th International Society for Quality Assurance in Health Care*. Maastricht, 1993, 27.
25. Ramirez A, Graham J, Richards M, et al. Burnout and psychiatric disorder among cancer clinicians. *Br J Cancer* 1995, 71, 1263-1269.