



EDUCATION FOR HEALTH

PERSONAL VIEW

In the News! An Opinion - The Theory of Practice

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Communication skills are the vehicle for the exchange of information, as well as the exchange of accompanying emotions, between patients and their doctors. In the past decades, much attention has focused on this core competency of doctors. A wide variety of training efforts has been described, their effects have been studied and the impact of good doctor-patient communication has been demonstrated related to many diverse outcomes - from increased patient satisfaction to lower demand for painkillers and reduced duration of hospital stays.

The communication skills training community seems to have their act together. Not only do they offer training in what they think is necessary material, but, importantly, they study the outcomes of these trainings, their impact on healthcare, and they meet to review and discuss this work annually in a conference.

At the 2007 International Conference of Communication in Healthcare, Charleston, South Carolina, USA, an interest group explored the theoretical bases of health communications research. It was recognized that, although there is a large knowledge base underpinning discrete communication skills, an overriding theoretical framework is lacking. Bits of the practical guidelines can be traced back to the values of Rogerian counseling, while other aspects are linked to systems theory. Guidelines for 'explaining' behavior and outcomes have their origin in cognitive psychological theories of the organization of memory as well as in the social psychological notion of stress as an intervening process. However, often the underlying theories have been found and added after the ideological position (e.g., "patient-centeredness") had been invoked.

In this regard, the conference session addressing the lack of an adequate theoretical basis for communication in healthcare was well attended. It set off a line of activities, ultimately resulting in a theme issue of the journal *Patient Education and Counseling* [74,



March 2009]. This theme issue is entirely devoted to the theoretical backgrounds and underpinnings of communication in healthcare; it is a gem for anybody remotely interested in the field.¹

What was the issue?

The first decade of research into doctor-patient communication mostly addressed lack of adequate exploration on the part of the doctor, and resulting negligence of the patient's agenda. Doctors were seen to frequently interrupt their patients during their opening statements and patients' emotions or even their main concerns were not being properly addressed.

The next 'generation' of studies described the success of various training formats and the risk that first year medical students' communication skills deteriorate spontaneously unless we train them. Later, studies tried to match the quality of doctor-patient communication to healthcare outcomes like patient satisfaction and objectifiable improvements in patients' health or circumstances.

The most recent studies have addressed specific phases of the doctor-patient encounter, especially in the area of shared decision-making. In view of these developments, it is not surprising that, at an organizational level, there is a feeling of the need to 'ground' our thinking within a theoretical basis.

Most of the original models for doctor-patient communication were seen as generic. They were valid for many different situations, types of patients and types of complaints. Critics claim that this could lead to oversimplification and rigidity. One of the ways of approaching this issue is to abandon the idea of a generic model.

We should instead focus on the various goals that can be accomplished in doctor-patient communication. Several possible goals are mentioned in a number of papers in the theme issue of *Patient Education and Counseling*. De Haes and Bensing's paper (2009) gives an excellent overview, leading up to the proposal for a new, encompassing 'six function model'. They strongly advocate prioritising the various goals in order to deal with them one by one. As wholeheartedly acknowledged by the authors, not all is solved with this approach. For example, some of the goals may obviously be contradictory to other goals. Another hazard of exclusively focusing on the goals in the encounter is that this may lead to a number of different discrete solutions, while each of these is still just as rigid as the generic model used to be.

Other papers in this issue address such topics as: the detection and monitoring of the possible goals that patients may have in the consultation; theories of persuasion; cognitive psychology of how people store and remember new information (and the role of stress here); a 'neurobehavioral' viewpoint; communication from the perspective of 'attachment'; organizational theory; and a review of studies on 'empathy'.

Most of the papers consider doctor-patient communication as a sequence of events, a 'value-chain' as it is referred to by Finset & Mjaaland (2009). One could alternatively look at Howie's concept of 'enablement', which takes the interaction as the focus of attention (Howie *et al.*, 1997).

The points that are addressed in this issue of *Patient Education and Counseling* are all based on previous work conducted in the Western European and Anglo-Saxon parts of the world. If and how these considerations may be different in other parts of the world yet remains to be seen.



Nevertheless, this issue is a must for everybody who wishes to advance their thinking about good practices in teaching in general and about teaching communication skills in particular.

Jan van Dalen
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Note 1: Even for those not interested in the field of communication skills it would be worthwhile to take a look at this endeavour. It is an example of how seriously we should go about trying to make sense of guidelines for clinical practice in general!

References

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