

Literature review on teaching communication skills to healthcare workers

Dr Clare Bentall

Lecturer in Education, Institute of Education, University of London

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1. Introduction

The purpose of this literature review is to inform the review of communication skills resources provided by Health Education North Central and East London, Professional Services Unit (PSU).

The aims are to identify best practice regarding:

- Effective teaching and learning strategies
- Appropriate approaches to incorporating patients' perspectives
- Inter-professional clinical communication skills teaching and specific situations that may require uni-professional support
- Specialist issues faced by healthcare professionals who graduated outside the UK

The results of the literature review will then be used to inform the review of communication skills courses currently offered by PSU.

The potential scope of this literature review is large, given the importance of this area in healthcare education and the array of healthcare professions that can be studied. In order to focus the literature review, as well as focusing on the areas identified above, two specialists in communication skills were consulted to identify key issues in the field. Then further search of electronic databases was conducted.

As the literature review has been written alongside the review of the communication skills courses there was also an iterative process adopted in looking for literature specifically related to issues that arose from the review of courses, and from conversations with the facilitators and PSU Communication Skills team. This review is therefore not a comprehensive review of all literature available, but more focused to addressing the key concerns of the team. The team works largely with doctors and nurses so literature on these groups was prioritised. In addition some articles looking at communication skills training for medical students are included where the issues raised are pertinent for the wider review.

In order also to reduce the scope searches of the electronic databases were limited to articles from 2000 onwards. There are some earlier articles included, either as they were recommended, or they give some of the historical background to the current debates. The structure of the literature review largely follows the aims set out above with additional sections. It begins with a discussion of the overall approaches to communication skills teaching, the focus on patient-centred approaches and the challenges this poses. Models and frameworks for guiding that approach are then considered, followed by a section on effective teaching and learning strategies. After this, some of the other key issues are considered in turn: incorporating patients' perspectives, retention of skills, inter- and uni-professional communication skills teaching, training for different levels and different professional groups and language and cultural issues. Finally there is a short section on the important issue of training for communication skills teachers.

2. Approaches to communication skills teaching

There is a fair degree of consensus across the literature in relation to effective teaching and learning strategies for communication skills. There are a number of useful review articles which provide overviews of the research, as well as a number of 'consensus' or other policy documents which outline current approaches (see for example Hulsman et al 1999, Makoul 2001 and von Fragstein, Silverman, Cushing, Quilligan, Salisbury, and Wiskin, 2008). The evidence is that generally communication skills teaching / training makes a difference to how clinicians communicate (see Aspergen's 1999 review and Stevenson, Cox, Britten and Dundar 2004) and also to patient outcomes. Importantly it is also associated with health and levels of job satisfaction amongst clinicians. Cantwell and Ramirez (1997) and Schofield, Green and Creed (2008) refer to literature on the potential link between job satisfaction and being able to communicate well (within cancer care in particular) and stress levels of clinicians. There is also a concern about the potential links between less effective communication and litigation. Although this should not be the prime motivation for addressing communication skills, it is an issue of increasing concern for the NHS.

There is variation in the studies as to how much effect different training interventions have, with some mixed results, and some indications that participants on courses show more development in some areas than others (see for example Kramer, Duesman, Tan, Jansen, Grol and van der Vleuten 2004, Berkhof, van Rijssen, Schellart, Anema and van der Beek 2011). There is however, nothing in the literature to suggest the current development and increase in focus on communication skills should be reversed, though there is more debate around which aspects of communication skills can be addressed on courses, whether courses have lasting impact, how they relate to the realities of communication in the workplace, which learning theories underpin approaches, as well as calls for more research. These issues will be addressed later on in the review.

One main area of debate which has implications for how the field of communication skills is viewed is around the overall approach. This debate captures not just how communication within the clinical setting and its purpose are perceived, but how this translates into approaches to learning.

Although the majority of the articles reviewed discuss 'communication skills', without problematising the notion of 'skills', there are a few voices that argue for a critical understanding of the term (see Salmon and Young 2011, Skelton 2011 and van den Eertwegh, van Dulmen, van Dalen, Scherpbier, and van der Vleuten 2013). Their main contention is that communication is more than skills, and that the focus on observable, objective behaviours that may result from thinking of it as only involving skills, reduces what is essentially a complex field into something atomistic, particularly when it is related to assessment. Salmon and Young (2011) argue communication needs to be seen as creative, holistic, and as a 'moral enterprise'. They argue that though it will involve the use of particular skills, such as maintaining eye contact, asking open questions etc, it is more important to consider how those skills are deployed in specific contexts with specific patients. Salmon and Young's (2011) argument is that patients themselves can exhibit

contradictory wishes in communication, for example cancer patients wanting doctors to be honest, yet also optimistic. A concern with the focus on specific behaviours, and whether or not they are used, is that not all behaviours are needed in all communication with patients, and sometimes breaking the 'rules' of communication might be precisely what is needed in a particular setting. Good communication in their view depends on whether both the doctor and patient experience it as such, remembering that what works with one patient may not with another. Real communication is characterised by uncertainty, therefore educators should be focused on aiming "for learners to make good judgements, to develop a style tailored to their individual characteristics, to develop the capacity to handle novel situations rather than simply delivering consistency, and to appreciate keenly the uncertainty surrounding their communication" (Salmon and Young 2011: 221).

Unlike Salmon and Young, Skelton (2011) does not argue directly for the dropping of the term communication skills, but he makes similar points about the nature of communication and the aims of education in this area. Drawing on the work of Hymes (1971) on communicative competence, which changed approaches to language teaching, he also argues, "We need to enable students and doctors to vary how they achieve the same goals in different contexts of use" (Skelton 2011: 213). One of his questions is about the link between skills and attitudes, wondering whether there is an assumption that if one teaches the skills the attitudes will follow or whether the focus should be on the teaching of the attitudes, which will lead to the development of the skills. As he points out, in assessment of communication skills, the objective, observable behaviours such as make eye contact, are always modified by words such as 'appropriate'. Some judgement is then still required as to what is 'appropriate' for a particular doctor – patient interaction, and marking the doctor as displaying the skill is not sufficient to identify good communication.

There is a wider debate around the teaching of attitudes, for which one needs to turn to the psychological literature. This is also a large field and cannot be covered in depth in this review. The main point to make is that it is not clear how attitudes and the individual skills link, whether the latter can be taken as an indication of the former. If this is the case then there is a question as to whether this link is explored in teaching, or whether the focus on skills, particularly at undergraduate level, means that attitudes are more likely not to be explored explicitly.

The positions set out above are not necessarily in contradiction to the view of those who teach communication skills, though they may disagree with Salmon and Young's more radical position regarding changing the name of the field of work, and they may see Skelton's oppositional view of skills versus holistic approach as too polarised. It can be argued that communication can be seen as both holistic and involving specific skills. For example, Lefroy and McKinley (2011) say such a creative, and holistic approach is precisely what is being aimed for in communication skills teaching, and refer to a 'toolkit' of skills and stress that it is the skill of knowing when and how to use them that is important. Von Fragstein et al's (2008) diagram of a curriculum of communication also presents the idea of layers, with the individual skills as one layer and patient-centred as another. The types of communication which clinicians need to learn to navigate also vary a great deal from more

routine to the less frequent complex consultations. Teaching communication skills requires, therefore, an approach that takes all this into account. Lefroy and McKinley (2011) also point out that communication skills need to be integrated with clinical skills, and that there is some danger that they get separated, even within arguments such as those outlined above.

There are those, however, whose main contention with articles about courses is that the detail on which behaviours and skills are covered is insufficient. Cegala and Broz (2002) build on a previous review by Hulsman et al (1999) and state that though an overall approach maybe clearly used, such as a patient-centred approach (see discussion below), there is insufficient detail over the breakdown of skills and importantly at what point each skill should be used in a consultation, and insufficient explanation of which theories underpin courses.

Skelton's (2011) argument that education in this area should not be about changes in behaviour but changes in 'state of mind' mirrors the theoretical debates about learning that underpin much healthcare education (see Bentall 2014). There is a tension between the more behaviourist understandings that focus on observable changes in behaviour and achieving specified competences, and the more constructivist position that focuses on learners' understandings. Most of the articles reviewed do not explicitly state which theories of learning underpin their approach, though many which focus on which teaching and learning strategies work seem to reflect a more behaviourist view, which reflects concerns within medicine, in particular, over the achievement of particular competences.

3. Patient-centred approaches

The majority of the literature reviewed argues for a patient-centred approach to communication, either directly or indirectly (see for example Jenkins and Fallowfield 2002, Stevenson et al 2004 and Coulter and Collins 2011). It is one of those terms, similar to 'learner-centred' in the education literature, which is used frequently, and not always with an explanation as to how it is understood. Before looking at the various models and research around patient-centred approaches it is worth considering what this term really means, as there are underlying assumptions within the literature about particular skills or behaviours that are deemed to demonstrate 'patient-centred' approaches. In line with the debate above, this can lead to an insufficiently complex understanding of the challenges in developing good communication skills.

Patient-centredness, on the face of it, means being focused on the patient and what their priorities are. However, this can pose a dilemma as the patient's preferences for styles of communication may contradict evidence around the best approach to communication for patient satisfaction and health outcomes.

Looking at the literature, focusing on the patients translates as an approach to consultation, which puts the patients at the centre. This includes aiming for joint decision making about treatment (when decisions need to be made), giving patients opportunities to share their

beliefs about their health, having a balance of discussion between professional and patient, and professionals asking patients for information (Stevenson et al 2004). It also involves recognising that patients have their own expertise with regard to their health which should be used in conjunction with the professional's expertise to reach decisions (Coulter and Collins 2011).

However, there is evidence that not all patients want to participate in consultations in this way and also evidence that patients assess communication skills differently from healthcare professionals (see Moretti, Fletcher, Mazzi, DeVeugele, Rimondini, Geurts, and Bensing 2011, Salmon and Young 2011). For example, Swenson, Buell, Zettler, White, Delaney, Ruston and Lo (2004) studied preferences of patients in the US for 'patient centred' or 'biomedical' approaches to consultations by showing videos of consultations to a sample of patients. 31 % preferred the directive, biomedical style.

Patient-centred communication usually translates as encouraging participation and joint-decision making, asking patients questions about how they view their health etc. However, one could argue that responding to a patient's desire for directive, less participatory communication, is actually more truly centred on the patient. This would imply doctors need, as Swenson et al (2004) would argue, some flexibility to be able to choose the approach that patients prefer. This would seem unproblematic if it were not for the research evidence that patients are more likely to follow treatment if they have participated actively in the consultation. The authors conclude that clinicians have therefore a more complex challenge of considering what style the patients prefer, whether to vary the style at different points in the consultation, and whether in fact to choose a style that is the best interests of the patient's health, though not necessarily in line with their preference. As Coulter and Collins (2011) point out those patients who may benefit most from a 'patient-centred approach', may also be those least used to participating and who prefer the doctor or other health professional to make the decisions (Coulter and Collins 2011). Skelton's (2011: 43), view is pertinent here, that "patient-centredness is not an objectively observable phenomenon: it varies from patient to patient and exists, therefore, not in a set of skills, but in the heart and mind of the patient".

The challenge for those offering training in communication skills, is in how to help healthcare workers navigate these difficulties, understand the basic principles of the recommended approaches, and develop a flexible and creative response to communication in the individual patient encounter. The degree to which this requires training on specific skills, or links specific skills to particular styles of communication, or the development of a more holistic framework is therefore something for teams of facilitators and educators to debate and decide in relation to education programmes that are offered.

3.1 Challenges for healthcare workers in adopting a patient-centred approach

The literature offers also an interesting insight into what the main issues are with healthcare workers in improving communication skills. In line with the aim for a patient-centred approach there is quite a bit of discussion about the need for healthcare workers to be more comfortable exploring the emotional aspects of the communication and what some refer to as the psychosocial approach to communication. This is in contrast to the skills related to information giving within communication which it seems doctors in particular, are generally more comfortable with, though this does not necessarily mean that this is not an area that needs addressing in their training.

Jenkins and Fallowfield (2002), amongst others, highlight the need for clinicians to see the value of a more patient-centred approach and argue that if this is valued by the clinician they are more likely to acknowledge the patient's feelings. They do point out, however, that there is a lack of research into the links between clinicians' beliefs about the importance of such approaches to communication and the skills of applying them. Some examples include Levinson and Roter's (1993) study which, though somewhat older, noted that the doctors with the most positive attitudes towards the more psychosocial aspects of communication had patients who offered their opinions and asked more questions. Similarly others would argue that healthcare professionals need to see the interests of the patient and their own interests as linked, that it is the relationship with the patient that is of importance, and that this requires some sense of emotional, as well as intellectual understanding (Ballatt and Campling 2011).

There are a number of documented reasons why these psychosocial aspects of communication are not explored by clinicians. Not all professionals view asking the patient's views as important, though, interestingly, when patients are clearly well informed the balance in communication does seem to shift to a more equal footing (Stevenson et al 2004). Other reasons include lack of training, lack of time, a degree of self-protection (Cantwell and Ramirez 1997), not wanting to upset the patient or feeling it would not help them (Schofield et al 2008) and feeling that they cannot solve the emotional problems the patients have (Hulsman et al 1999). Wheatley-Price, Massey, Panzarella, Shepherd and Mikhael (2010) conducted a survey of residents working with lung cancer patients in Canada and concluded that doctors can become more comfortable with this aspect of communication with time, whereas other authors are not convinced that experience on its own necessarily improves the ability to communicate. Bleakley and Marshall (2013), for example, argue that empathy actually degrades in the workplace, under the influence of hierarchies and other pressure, resulting in less positive views of patients and colleagues.

One feature that is noted in consultations is the use of blocking tactics used by the healthcare professionals. Schofield et al (2008) call these 'inhibitory behaviours', when a clinician notes the patient has expressed a more negative emotion and moves to cut off any further exploration of that issue. They quote research by Wilkinson (1991) which identifies these behaviours in nurses, and notes that some nurses are more facilitative than others and some more inhibitory, but often also without realising it.

Légaré, Ratté, Gravel and Graham's (2008) review of barriers to shared decision-making also concludes that time constraints are the biggest barrier, followed by lack of agreement of how to apply shared decision-making. Interestingly, given the discussion above on patient preferences, they suggest that clinicians may be judging in advance and not necessarily correctly, as to which patients would prefer such an approach. The authors also conclude that shared decision-making is more likely to occur when health professionals are motivated to apply it, are convinced that it is beneficial for patients and their health outcomes. Clearly applying a patient-centred approach to communication is not straightforward, and the complexities are therefore important components of communication skills teaching.

4. Models and recommended frameworks

Despite the difficulties with applying a patient-centred approach, it remains at the heart of discussions on communication skills teaching, not least as there is a view that this is still something health care professionals do apply as much as they should (Stevenson et al 2004, Coulter and Collins 2011).

There are various models, principles and consensus frameworks identified in the literature, which both address the more fundamental understandings of what patient-centred might mean, and also identify, with a degree of consensus, specific behaviours and skills which are then associated with the idea of patient-centredness. These models focus on the consultation with patients, and then are used as a guide to teaching communication. There are also models for aspects or approaches to teaching communication, such as those focusing on giving feedback, for example. In this section those relating to the overall approach to consultation will be discussed and those related more specifically to aspects of teaching are addressed in the following section.

There is a historical development of various consensus statements on communication skills based on periodic reviews of research and discussions between professionals. The latest is The UK Consensus statement, developed for the UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education (von Fragstein et al 2008). It has similar elements to the Kalamazoo statement, which is also set out below.

The von Fragstein et al (2008) framework is for a curriculum for undergraduate medical education, which is not designed to be a list of competences to be achieved, but is based on a number of domains and overriding principles. However, they do also list some of the discrete skills that can be observed, stressing this is in the context of the primary purposes of building a relationship with the patient. These are all seen as inter-related with the overriding principles, therefore the model is offered as a series of layers.

The overriding principles they advocate are reflective practice, professionalism, ethics and law and evidence-based practice.

The domains include: respect for others, theory and evidence of communication skills (eg links to reducing error, medical outcomes), tasks and skills of clinical interview (eg building relationship, recognising patient needs, explaining diagnoses), specific patient issues (eg age, culture), media (eg face to face, telephone), communicating beyond the patient (eg with relatives, other doctors or professionals) (p 1102).

The discrete skills they list include: Eye contact, facial expressions, attentive listening, screening, balance of open and closed questions, facilitation, empathetic reflection, responding to cues, summarising, signposting, determining patient's starting point, chunking information, checking patient's understanding (p1103).

The Kalamazoo Consensus statement (Makoul 2001) developed out of a Bayer-Fetzer conference on Communication in Medical Education in May 1999. In this conference the participants reviewed 5 models of communication:

- The Bayer Institute for Health Care Communication E4 model
- 3 function/ Brown interview checklist
- Calgary-Cambridge observation guide
- Patient-centred clinical method
- SEGUE framework for teaching and assessing communication skills.

Although there are differences in the detail of the models, they concluded that the following commonalities exist:

- Build a relationship
- Open discussion
- Gather information
- Understand the patient's perspective
- Share information
- Reach agreement on problems and plans
- Provide closure

Earlier consensus statements include the Toronto consensus statement in 1991 and one from an international conference in Oxford 1996 on Teaching Communication in Medicine (Makoul and Schofield 1999). Although the Oxford statement focused on medical schools the recommendations are relevant for post-graduate training also.

These are:

- teaching and assessment should be founded on a broad view of communication (ie including communication with relatives and other doctors, written and oral presentation skills);
- communication skills teaching and clinical teaching should be consistent and complementary;
- teaching should help learners achieve patient-centred communication;
- teaching should help learners' grow personally and professionally;

- teaching should be based on a planned and coherent framework;
- abilities with communication tasks should be assessed directly (ie providing feedback)
- teaching programmes should be evaluated;
- development for teachers of communication should be provided

Some authors list various aspects of communication that are important, which have much in common with the consensus statements. For example, Coulter and Collins (2011:25) who identify: 'developing empathy and trust, negotiated agenda setting and prioritising, information sharing, re-attribution, communicating and managing risk, supporting deliberation, summarising and making the decision, and documenting that decision'. Helping patients articulate what they want, understanding how they see their condition, and making sure they understand and can articulate their understanding of risk is key.

Alongside these consensus statements there are also then a series of models which are either designed to be generic or more specific to certain types of communication. From the Kalamazoo statement, the Calgary-Cambridge observation checklist is quite commonly cited and used across disciplines and for a range of communication contexts.

Other models are designed for specific types of communication or specific intended patient outcomes. One such is 'motivational interviewing' (see Levensky, Forcehimes, O'Donohue and Beitz 2007). This is an approach to counselling based on evidence around behaviour change, which is useful for helping patients follow recommended treatment options. Levensky et al (2007:4) discuss it in relation to training nurses in particular for situations where patient ambivalence is an issue.

The techniques include:

- not offering to fix things for the patient,
- respecting autonomy of the patient,
- expressing empathy,
- developing a 'discrepancy' (so that the patient can see this in their response),
- going with any resistance that is offered and
- supporting the patient's self-efficacy.

The skills required for this are common to other models of communication: reflective listening, asking open questions, affirming and summarising and about knowing what stage in the process of behaviour change the patient is at and responding appropriately.

Another example is 'cue-based interviewing'. Schofield, Green and Creed (2008) discuss this approach in relation to communication within cancer care. This requires the healthcare professional to pick up on a suggestion by the patient of some worry or problem, or negative emotion. Although there are difficulties in reaching a consensus as to how to define a 'cue' there is evidence that focusing on these cues is more proactive and more centred on the

patient. They quote research by Fletcher (2006 in Schofield et al 2008) indicating that when open questions are used in response to such cues it is much more likely that the patient will disclose important information, than if the questions are all based on the clinician's agenda. The research also indicates that if the first cue is missed then the patient is more likely to not give further cues.

Beard, Beard and English (2009: 497) refer to 'needs based communication' (NBC) which is useful, they argue, for communication with patients and with colleagues. It focuses particularly on 'resolving difficulties, building trust (especially across interdisciplinary boundaries), avoiding complaints and diffusing anger'. It is based on 4 principles of knowing the difference between 'objective observation and subjective evaluation', knowing how to express needs, know how to meet own needs whilst taking into account the needs of others, understanding feelings as being the voicing of needs.

Crossley and Davies (2005) suggest a framework for doctor patient interactions involving parents and children, resulting from a survey of the literature, and consultations with a panel of paediatricians. They identified a list of doctor characteristics, doctor tasks and final outcomes from consultations. This list is too long to include here fully, but it is interesting to note that under doctor characteristics they list mainly skills, with just one attitude or orientation: interpersonal skills, information gathering, clinical questioning, patient-centredness (which includes parent-centredness), information-giving, clinical judgement, consultation management, clinical knowledge, physical examination. This framework overlaps with the Cambridge-Calgary observation guide (Kurtz and Silverman 1996), and the Leicester Assessment Package (Fraser, McKinley and Mulholland 1995).

Hulsman, Ros, Winnubst and Bensing (1999) review a number of studies and categorise the types of behaviours involved in communication in those studies as receptive, information and interpersonal / affective behaviours.

There is also the Lipkin model (see Fallowfield, Lipkin and Hall 1998), which is based on adult learning theory, the use of tasks and group work for skills. This involves participants identifying their own needs, working on skills with simulated patients, doing a video review and group critique. Other methods used in this model are group demonstrations, discussion and looking at key readings, plus video recordings of interviews with patients and relatives.

The SPIKES model is particularly used for breaking bad news (see Baile, Buckmann, Lenzi, Glober, Beale and Kudelka, 2000) and the SBAR Technique: Situation, Background, Assessment and Recommendation, is used for communication between colleagues, particularly for hand-offs (see Kesten 2011).

These are just a few of the models and frameworks that exist in the literature and that can inform the development of communication skills programmes. They have a great deal in common, not least as a result of the consensus over the need for a patient-centred approach, even if what that might mean in practice is debated. Although all these models and approaches exist it is not always clear from programmes which models or theories of

learning underpin the approaches used. As an illustration, in the Netherlands, Veldhuijzen, Ram, van der Weijden, Wassink and van der Vleuten (2007) looked at 8 GP training programmes to identify the guidelines used for communication skills. Not only were guidelines they found not mandatory, but many programme leaders had difficulty identifying them for their own programmes, and there were occasional inconsistencies within programmes. This would suggest that much of the discussion of the effectiveness of programmes leaves implicit the theoretical underpinnings and understandings of communication that those running such programmes are using, both in reporting within the literature, but possibly also in communicating with those taking the programmes.

5. Effective teaching and learning strategies

Have identified the overall approaches and the range of specific skills and characteristics recommended in the literature for effective communication, it is important to consider how those are best taught.

There is evidence that training can result in more positive attitudes to patient-centredness and more implementation of the skills associated with this approach (see Fallowfield et al 1998, Hulsman et al 1999 and van Es et al 2013). Jenkins and Fallowfield's (2002: 768) study of the beliefs of senior and junior doctors in oncology demonstrated that attitudes change after training and that training needs to include "cognitive, affective and behavioural components", though they were unsure whether one component was more responsible for the change than the others. They concluded that any doctor with a strong belief at the outset of training that such psychosocial aspects are not important is likely to block any change, so courses need to include activities to explore the links between such aspects and the effect on the patient and the clinician.

Some of the studies show also that training can have more of an effect on the psychosocial aspects of communication, than the information giving aspects, particularly if the participants start with a low ability in this area (van Es et al 2013). This is an important point as it is not always clear from the studies what level participants started at or whether they were identified as having problems (Berkhof et al 2011). There is likely to be a difference in results between participants already enthusiastic and committed to developing their communication skills and those who are reluctant, and those with complex problems in relation to communication and those without.

There is also some evidence that female clinicians are more interested in the psychosocial aspects of communication and less directive (Laidlaw, Kaufman, MacLeod, van Zanten, Simpson and Wrixton 2006), though there is debate that differences could also be speciality related. Laidlaw et al (2006) also found younger doctors did better than older doctors in a study involving 78 participants doing each of 4 videoed OSCE consultations.

Berkhof et al's (2011) article provides an overview of various reviews of literature in this field, identifying what works. Their review focuses predominantly on what works with those already qualified in curative medicine. Although not all the articles they reviewed were of similar quality, nor were clear exactly on what teaching strategies were used or even how communication skills was defined, they do note some consistent findings.

Their conclusions are that the learning needs to be learner-centred, active, interactive and experiential. There is a logical parallel here with a desire to be patient-centred in communication. Teaching which models a learner-centred approach is likely to mirror the types of approaches being recommended for communication. They conclude that courses outside the workplace need to last a minimum of one day, though preferably longer, and small group teaching is best. Jenkins and Fallowfield (2002) also note that participants attending a 3 day course show better retention than those attending for the half the time. Berkhof et al (2011) point to the need for more research into whether or not intensive courses over a few days would be more effective than shorter sessions over several weeks. In terms of teaching activities, they identify the most effective approach as practice through role play, particularly using simulated patients, with feedback. Small group discussion around communication issues is also considered effective to a degree, though the results are not conclusive on this. Written information or presentations or modelling by facilitators are potentially helpful, but in conjunction with practice of skills with feedback.

(Much of what is referred to in the literature as 'role play' is not strictly speaking role play as the clinicians involved are being themselves. For the doctor or other healthcare worker this is in fact experienced as a simulation, even though the people playing the patients are in role. However, as much of the literature refers to 'role play' this terminology will be used in this review, with the understanding that this generally refers to simulated consultations).

The findings of this review chime with individual studies, which predominantly use a form of role play / simulated consultation with feedback. As Noble and Richardson (2006: 25) point out, it is the combination of practice and feedback that is important, rather than relying on learning of communication skills purely through 'experience without reflection'.

There are also examples of other additional techniques and materials. Al Odhayani and Ratnapalan (2011) list some others in their review:

- watching teachers, though they conclude there is not much evidence that this leads to long term changes in behaviour in learners;
- watching videos of teachers as a form of modelling best practice, allowing time for discussion and reflection;
- watching videos of learners, which is good for self-reflection and highlighting non-verbal behaviours.

One other interesting example, which is a variation on role play, is the use of Forum Theatre (Boal 2008). Middlewick et al (2012) discuss its use for teaching healthcare students, in particular nurses. Forum Theatre involves staff / facilitators acting out scenes that have been scripted and in which the outcome is less than positive. Students are then asked to interact

with the characters and attempt to achieve a more positive outcome. The value, they argue, links back to the debate at the outset of this review. Students do not learn a fixed way of communicating, as they are encouraged to try various options and adapt their style of communicating in response to the patients. They can, for example, ask for parts of the scene to be replayed in a different way. The idea is to engender discussion amongst those watching, give them the opportunity to try out alternative approaches. As it is a dramatic technique, the authors argue that it also help students explore their emotions and that of patients, particularly in scenarios that are challenging. They argue it promotes a deeper level of reflection, and helps to demonstrate what instructions such as 'be empathetic' actually involves.

The value of role play / simulated consultations is that they provide opportunities to practice in a safe environment, with no risk to patients and there is evidence that it leads to good retention of knowledge and skills (see Al Odhayani and Ratnapalan 2011). Using this technique in small groups also allows for more than one person to help in solving any communication difficulties.

Videos are mentioned in a small number of cases, and examples include the use of videos of real consultations (Morris et al 2001).

As with models of overall approaches to consultation there are also some models specifically designed to help with the teaching of communication. One important aspect is the giving of feedback to learners after the role play / simulations discussed above. Two examples of are the, ALOBA model (Kurtz, Silverman and Draper 2005) and the Pendleton model (Pendleton, Schofield, Tate and Havelock 1984).

Others concern the overall teaching approach. For example, Watmough, Garden and Taylor (2006) look at the effect on the use of Problem Based Learning (PBL) within the University of Liverpool on the learning of communication skills at undergraduate level. They found those who had experienced this type of approach demonstrated better communication in the workplace as junior doctors, particularly in terms of taking histories and listening to patients.

Another interesting approach is the use of Conversation analysis (CA). Dias (2006) and Heritage and Maynard (2005) view this as a way of helping clinicians learn how use of language, non-verbal behaviours and talk affects communication. CA involves looking at 5 aspects of doctor – patient communication: "utterances as social activities, sequencing, interactional detail as a site of organisation, analysis of participant orientations, single cases and collections" (Dias, 2006:3). An example of the first would be saying 'hello' rather than 'this is a greeting: hello'. The second is about taking turns, the third refers to elements such as silence or talk that overlaps. The fourth refers to speakers deciding whether what they have tried to say has been understood in the way they wish by the other person. If not then they use the next opportunity to correct any misunderstandings. The last refers to looking at whether individual people have patterns in their communication.

As with the interpretation of patient-centred approaches to consultation, there is a similar level of consensus with regard to the most effective teaching strategies, as well as some particular models that can be helpful.

6. Appropriate approaches to incorporating patients' perspectives

As is clear from the section above, the use of 'simulated patients' (ie actors or role players playing the patient), is well established. In the articles included in this review there is nothing to indicate the use of 'expert patients' in any routine way (ie real patients being used in practise situations on training courses). There are examples of choosing role players to give a particular perspective, such as using teenage actors to simulate teenage-like responses to doctor-patient consultations, particularly around sensitive issues (Hardoff and Schonmann 2001), or using simulated family members in a workshop for postgraduate subspeciality critical care medicine trainees to help them focus on ethical and legal issues in particular around the treatment of their relatives (Downar, Knickle, Granton and Hawryluck 2012). There are also examples of videos of discussions with relatives of patients suffering from cancer which are used to provide an alternative perspective and use of videos of real patient encounters in follow up to training (Jenkins and Fallowfield 2002, Fallowfield et al 1998).

Although the use of simulated patients is considered effective there are a number of issues that have implications for how these are used on training courses. The literature cited here relates to studies with medical students, but raises questions which could be considered for training of qualified healthcare professionals. Yardley et al (2013) looked at medical student experiences of both simulated and authentic patient consultations. They concluded that using the former before the latter was a safer approach as there is a need to prepare students for the workplace, a conclusion shared by Schaufelberger et al (2012) looking at their use with medical students in Switzerland. Although the simulated encounter can offer preparation for the more challenging consultations which can give medical students a greater sense of what is required with real patients (Schaufelberger et al 2012), it does not fully prepare them for the reality of patient's emotions (see for example Yardley et al 2013). As De La Croix and Skelton (2009) put it, simulated patient consultations are not a true reflection of real patient consultations, which needs to be understood, though they offer an effective opportunity and means for healthcare professionals to develop their skills.

There are some other points worth bearing in mind from these particular articles. One is that real patients do not necessarily give feedback, so although there is greater authenticity, there is not the same opportunity for reflective discussion afterwards, nor is there the same chance to pause the communication and ask advice. Yardley et al (2013) also note comments from medical students about feeling that the simulated patients have been given particular instructions, resulting in students feeling a little manipulated, and therefore raising the issue of how the role players are prepared and briefed.

De la Croix and Skelton (2009) carried out research on the degree amount of talk and interruption in role plays between SPs and Y3 medical students. In contrast to other studies with doctors with SPs or real patients, SPs talked and interrupted more, indicating greater 'dominance' in the consultations. Although there are various limitations to the study (sample size and the quantitative way of measuring talk and interruptions), they concluded that the institutional setting of the role play gave the SPs a confidence and authority which they would not have in other situations, particularly if the communication is being assessed. Not only is more SP talk associated with higher grades, they also concluded that some scenarios will lead to more talk by the simulated patient, whether or not the student is trying to encourage it. This has implications for how those assessing or giving feedback on communication training courses relate the amount of simulated patient talk to notions of patient-centredness. Although the same issues have not emerged in literature reviewed for qualified doctors or healthcare professionals, they are worth bearing in mind as issues to be alert for in training courses for those groups.

It is also worth noting that there is a wider literature on the role of patients as teachers within healthcare education, which has relevance for communication skills teaching, even if the focus is broader. For example, Thacker, Crabb, Perez, Raji, and Hollins' (2007) article looks at involving those with learning difficulties in teaching students.

There are a number of ways patient perspectives can be incorporated into communication skills teaching, though the most common and well documented is the use of simulated patients.

7. Retention of skills and transfer of skills to the workplace

Much training of communication skills takes place outside the workplace, either during initial qualification or post-qualification on specific communication skills courses. There are a variety of reasons for this, some of which have been mentioned above. One is the use of simulated patients, which offers a safe environment for learning, and certainly for initial qualification training appears to be partial preparation for initial clinical experiences. There may also be certain groups of post-qualification participants who need extra support for communication skills so need to access some 1:1 support or to join courses that are offered outside their institution.

This raises a number of issues around retention of skills, transfer of skills, and the match between what is taught outside the workplace and practices in the workplace. Various writers point to the problem of healthcare professionals learning a particular approach to communication skills within a course and finding for various reasons that this is not possible to apply them back in the workplace (see for example van Dulmen and van Weert 2001, Heaven, Clegg and Maguire 2006, Salmon and Young 2011, Brown 2012, van den Eertwegh et al 2013, and Yardley, Irvine and Lefroy 2013). There is therefore a need to think about how communication skills courses link with practice in the workplace and how to support healthcare professionals in applying what they have learned.

As discussed above in relation to medical students and the use of simulated patients, despite a greatly increased amount of training in communication skills clinicians still have difficulty with communication, particularly issues such as breaking bad news, dealing with seriously ill children or with difficult patients, for example. Van den Eertwegh et al (2013) argue that there are a number of influences within the workplace that make transfer of learning from the institutional context difficult: workload pressures, inappropriate modelling by other professionals, or the characteristics of particular trainees. As Heaven et al (2006) also argue, the workplace is a stronger influence than an individual training course. As well as providing communication skills training consistently throughout all stages of training, with consistent messages as to what approaches to communication are recommended, there is also a need to contextualise what is learned, to increase the chances that the learning can be transferred. Van den Eertwegh et al (2013) and others (see for example Brown 2012) would argue therefore for a theoretical approach to communication skills teaching which is based in theories of workplace based learning (see for example or Lave and Wenger 1991 and Engstrom 2001).

One response to this challenge is to designing training courses with inbuilt follow up (Heaven et al 2006). Supervision in the workplace is also important to support the retention of communication skills (see Silverman and Wood 2004). Success is also dependent on the willingness and intention of the healthcare professionals to apply what they have learned in the workplace (see Hulsman et al 1999).

Heaven et al (2006) conducted a study with 61 clinical nurse specialists, who attended a 3-day workshop on communication skills, with 29 then offered 4 weeks of clinical supervision as follow up. Although acknowledging that the 4 weeks of supervision was likely to be insufficient for full transfer of complex skills involved in communication, they did find that those offered the clinical supervision did improve certain aspects of their practice, in contrast to the control group where there was some evidence of some loss of skills. Drawing on the literature on transfer of learning they conclude that 3 elements are important: a 'supportive environment' for the learner, a space to discuss incorporating the learning into practice, and helping the learner to reflect on experiences of trying to applying learning, both negative and positive, in an objective way, so that they develop an understanding of the difficulties involved (p314).

Ensuring the consistency of approaches to communication between different contexts is difficult. Brown's (2012) article considers this question in relation to medical education and the workplace. She points out that doctors within the workplace have not necessarily been trained in the same way as the teachers in medical schools, particularly if in medical schools teachers come from the social and behavioural sciences. The knowledge that is valued in the one context may not be equally valued in the other, and she suggests that there needs to be a greater teaching partnership between the different contexts. Whilst this article relates to the medical school context, there is a parallel issue with post-graduate training courses outside the workplace, which may use a mix of clinical and non-clinical facilitators. Van Dulmen and Weert (2001) also conclude that there needs to be training at all levels, for

example, consultants and junior doctors, so that this consistency and transfer can be achieved. It could also be argued that teaching communication in the workplace would address the dilemma expressed at the outset over the focus on particular communication skills and a holistic approach, as it would allow clinicians to explore first-hand the integration of those individual skills with their overall approach and attitude, and the effect on the patient.

8. Inter-professional clinical communication skills teaching and specific situations that may require uni-professional support

One answer to the dilemmas posed with regard to transfer of skills may be to run courses in the workplace, and to work with teams of professionals who are therefore learning the same skills for communication. Such inter-professional approaches are increasingly advocated within healthcare education in general, not least as there is evidence that clinical error is often the result of communication problems within clinical teams and that inter-professional communication reduces such error (Dixon, Larison and Zabari 2006, Guise and Lowe 2006). In this section studies looking at inter-professional communication skills learning are discussed, as well as any evidence for the value of uni-professional training.

Before doing so some clarification of terms is necessary. The literature on clinical education has terms such as 'shared learning', 'multi-professional learning', 'team working' and 'inter-professional learning'. The definitions used here are that inter-professional learning is where the aim is to learn from each other, multi-professional is where learners learn something alongside each other, but not collaboratively, and team working is where people work together with respect for their individual roles (CAIPE 2006, Skinner 2007). 'Shared learning' and 'multidisciplinary learning' are also used as alternatives to 'inter-professional learning' or 'inter-professional education (IPE)' (Skinner 2007). Different healthcare professions are likely to favour different forms of learning, and use different terms, which reflect their views on the value of and nature of learning across professions (see Bentall 2014).

There are not many studies which illustrate inter-professional learning. One example is Collet al's (2011) article on IPE within primary care. They consider all aspects of IPE in this context, one of which is communication skills with patients and with colleagues. One of the main arguments in favour of this inter-professional approach is that the communication and work with patients is inter-professional in nature. Most decision making with regard to patients will involve more than one professional. The specific communication skills for this inter-professional setting they highlight include both the basic communication and consultation skills all doctors need, plus those relating to team communication. These consist of: 'handling and resolving conflict', 'organising and facilitating meetings', and 'negotiation skills' (p411) – ie dealing with the power relationships between professionals. The methods they recommend using are a combination of presentations on core issues, which could include use of videos, as well as experiential interactive methods for practice, such as role play in which different members of the team need to help the patient in making a decision, followed by group reflection.

Sargeant, McLeod, and Murray (2011) looked at a particular approach to inter-professional teaching of communication skills for cancer care. The programme consisted of 2 hour workshops, using role play, on particular themes: 'essential communication skills', 'delivering difficult news and providing support', 'when patients and families are angry' and 'managing conflict in the workplace'. 17 workshops were run with 518 health professionals from 20 different professions, with nurses comprising over half of the participants. In contrast with what Col et al (2011) are recommending, this was not aimed at specific teams in the workplace, but different professionals learning together and benefiting from understanding each other's perspectives and approaches. There was some discomfort reported about role play in front of others, though the authors do not specify whether this was related directly to the differences in profession or the usual discomfort individuals feel performing in front of others. In terms of the impact on inter-professional working, they report a greater respect for other professions on the part of the participants, as well as increased communication between different professions and more positive responses from patients 3 months after the workshops.

A third, slightly different example is Morison and Jenkins' (2007) article on inter-professional shared learning with medical and nursing students, in both the lecture and clinical practice settings. The study involved some who had the full shared learning experience, some who had a partial shared learning experience (only lectures) and some who had none. The first group demonstrated a more open attitude to talking about patients to other professionals and to working as part of a team. Those who had not received any shared learning or only in lectures were more negative about the value of this approach. The issue for the authors is in helping students see 'their professional identity as more collaborative' (p455).

The final example offered is not strictly inter-professional, but inter-speciality. Rentmeester (2007) looks at what she calls 'reason exchange' in relation to communication between trainee generalist and specialist doctors. She argues that the ability to reason will affect the degree to which differences of opinion over treatment and the associated communication are negotiated. Reason exchanged consists of 'giving reasons, listening to reasons given by others, evaluating reasons and deciding which particulars of situations constitute reasons to act and reasons how to act' (p308). The article looks in particular at communication between radiologists (an example of a speciality that does not require much patient interaction) and generalists (who have a lot of contact with patients). However, the issues may also apply to other collegial interactions. She concludes that reason exchange is part of the negotiation skills that all doctors should develop.

There is still scope for much more research into the area of inter-professional communication skills training, as the vast majority of the studies are uni-professional, and often, uni-speciality in scope. Given that that is the starting point of most articles there is little discussion as to why communication skills need to be taught uni-professionally as opposed to inter-professionally. It is how most healthcare education has been organised historically. Even the topics of communication skills training courses that might be more common or complex for some professionals than others, such as breaking bad news to seriously ill cancer patients, for example, would be relevant to team training within the

workplace setting or multi-professional training outside the workplace. Having said that the literature does point to the overall effectiveness of communication skills training in how it has been run to date, but there is no evidence cited that this is as a result of the uni-professional setting. It is also arguably the case that much of the focus on inter-professional working in general has to some extent focused on different healthcare professions working with each other, rather than how they together work with patients. Therefore there is the need for more thought on how this inter-professional approach might be integrated into overall approaches to communication skills training with its focus on communication with patients. One example could be the use of patients to help develop communication scenarios for use with mixed groups of professionals (see for example Kilminster et al 2004 and Kilminster and Fielden (2009).

9. Training different professions and levels

9.1 Training post-graduate doctors and more senior clinicians

One question of relevance to the wider review on communication skills training provision relates to the different levels of doctors, those in training and those at consultant level. There is not a great deal in the literature that addresses this directly. Berkhof et al's (2011) review suggests behaviour change in more experienced clinicians can be an issue, but their review does not highlight great differences in how different learners were trained. They also point to the smaller number of studies of work with more senior medical professionals. Of the studies that are included here, Hulsman et al (1999) conclude that more experienced doctors can be trained. Fallowfield et al's (1998) study also demonstrates that training does work with more senior doctors, and they also conclude that senior doctors (within oncology) do report problems with communication, even though they are more experienced, particularly with the more emotional and interpersonal aspects. What does seem clear from these articles is that regardless of level of doctor or other health professional, and regardless of speciality, the same approaches to teaching communication skills are considered effective.

Other examples of articles focusing on post-graduate doctors include Watmough et al's (2006) discussion of the teaching of communication skills within the PBL curriculum at the University of Liverpool for Pre-Registration House Officers, with positive outcomes for those who had experienced it, as was mentioned above. Beard et al (2009) discuss another model for junior doctors and Laidlaw et al (2006) look at the characteristics of trainee doctors. This last study concludes that there is a link between characteristics such as gender and age and communication skills, but that also communication proficiency is also linked to levels of clinical knowledge.

One article of interest to this review relates to 1:1 support for medical students and qualified doctors who are identified as experiencing issues with communication. Cohen,

Rollnick, Smail, Kinnersley, Houston and Edwards (2005) are particularly concerned with the stress associated these challenges and the resulting effects (such as anxiety). The article focuses on 1:1 support provided by one particular Communication Skills Department in one university in the UK. This support includes coaching, training, and when the individual referred agrees, reports on their progress being shared. They approach this individual support by assessing needs and then agreeing a programme. This is very important, they argue, as students or doctors are referred on a generic communication skills difficulties basis and as this can involve a variety of issues (including things like bullying at work or being new to the culture), this assessment is a key part of the support. The types of issues they list that they have dealt with include: skills, personality / style of communication, mental wellbeing, language difficulties or difficulties in adapting to the culture and finally, inter-professional communication.

They discuss the challenges of providing this service, of sitting between medical education and occupational health. A key principle is making clear what their role is to the people referred to them, and whichever organisation sent them. The second important principle is confidentiality and being independent. They also point to the need for good skills on their part, not just listening, but coaching on particular skills. They also do a follow up questionnaire which asks about more than just skills. They say there is a need for this type of remedial work, but would prefer that such problems were addressed earlier, rather than dealing with them when there is a crisis, so they also emphasise the need for good undergraduate communication skills training.

9.2 Differences between professions and disciplines

As many of the studies are discipline or speciality specific there are some interesting issues around the nature of each profession / speciality which are relevant for debates about inter-professional or multi-professional learning.

Unsurprisingly there is a lot of literature about communication within cancer care, related to both doctors and nurses, and quite a bit on GP training, as well as on medical students. There are then a few studies looking at other medical specialities in particular.

One particularly interesting study compared 4 residency communication skills programmes in Canada, for 4 different specialities: surgery, obstetrics and gynaecology, paediatrics and internal medicine. Each speciality was trained separately but using the same programme with generic materials, such as role play scenarios, that could be made speciality specific. The facilitators came from within each speciality. In this study Razack, Meterissian, Morin, Snell, Steinert, Tabatabai and Maclellan (2007) note that there is a 'hidden curriculum' within specialities in relation to communication. Although there were commonalities in the communication issues faced by the different specialties, there were also distinct differences noted between paediatrics / internal medicine and surgery / obstetrics and gynaecology in approaches to communication, responses to role play as a learning activity, and the communication outcomes. The former pair of specialities were more comfortable with small

group work and role plays, were focused also on how to teach communication to more junior doctors, and more focused on reflection. The latter two specialities were less comfortable with the role play learning methods and more focused on achieving required competences and basic skills acquisition. Also in the surgery course there was much more facilitator talk than in the others and concern about senior doctors doing role plays in front of junior members of the team. The results of this study relate to a specific institution so the authors do not claim a wider generalisation, but the study does illustrate how different specialities may respond to training, and what their aims are in the teaching of it. The study also hints at the influence of the workplace on how junior doctors may be inducted into ways of communication that may or may not chime with their previous training.

Other articles which are speciality specific include: Veldhuijzen, Ram, van der Weigjden, Wassink and van der Vleuten's (2007) article looking at the guidelines for doctor-patient communication in 8 GP training courses and Kramer, Duesman, Tan, Jansen, Grol and van der Vleuten's (2004) article on postgraduate GP training. Within cancer care, Cantwell and Ramirez (1997) discuss a study into junior house officers' views on their communication skills with cancer patients and Wheatley-Price, Massey, Panzarella, Shepherd and Mikhael (2010) look in particular at trainee doctors' abilities to discuss bad news with patients with lung cancer. Other specialities covered in the literature include: Chan, Wallner, Swoboda, Leone and Kessler's (2012) article on emergency medicine and the assessment of communication skills; Van Dulmen and van Weert's (2001) look at interpersonal communication skills amongst gynaecology consultants (in the Netherlands) and Harms, Young, Amsler, Zetler, Scheidegger and Kindler's (2004) article on anaesthetists (in Switzerland),

Most of these studies or articles do not address the specific needs of the speciality, but rather are concerned with whether or not the research shows improvement in particular or general communication skills. Harms et al (2004) conclude that it is not clear which communication skills need to be taught to which specialities and Chan et al (2012) point out that research done with primary care and palliative care is valuable particularly in relation to issues such as breaking bad news.

There is also a view that communication skills is an area that needs more attention within dental education (Woelber, Deminling, Langenbach and Ratka-Krueger 2011) and that there is some reluctance in dental schools to assessing consultation skills. However, as this article relates to Germany it is not clear the degree to which this reflects the UK context.

There are no clear conclusions on the benefits of teaching communication skills uni-professionally, as opposed to with mixed groups of professionals, as the two have not been directly compared in any systematic fashion. There are clear benefits noted to the inter-professional or multi-professional approach where it has been tried and similarly most of the studies which happen to focus on uni-professional training also report positive impacts on communication skills. There are suggestions that different specialities in particular may view communication differently. This could arguably be seen as a reason for mixing specialities so that there are opportunities to learn from others, and not just be inducted into a particular way of doing things.

10. Language and cultural issues

One of the concerns for the communication skills courses review relates to the particular needs of those healthcare professionals who graduated outside the UK and are trying to integrate into the UK healthcare culture. In this section a small number of articles specifically dealing with the teaching of communication skills to healthcare professionals who do not have English as a first language and general cultural issues in communication are discussed. It should be noted however, that there are potentially many more useful articles available from the field of language education which could be consulted.

The section also looks more widely at cross-cultural issues, as the literature identifies that it is not just those without English as a first language, or those trained overseas, who need to consider cultural issues within communication, so a small number of articles relating to those wider issues are also discussed.

10.1 Specialist issues faced by healthcare professionals who graduated outside the UK

There are not many articles addressing non-native speakers directly in relation to healthcare workers, which of itself is worthy of note, as this is an area that is of importance to the health service and also to those running communication skills training. It is also an issue that is not new (see Chur-Hansen, Vernon-Roberts and Clark 1997).

There are concerns about particular issues in relation to non-native speakers of English, which do include their general language abilities, but also whether they can communicate in the way that is advocated within healthcare professions. Skelton et al (2001), for example, ask whether the whole concept of patient-centredness translates across cultures. As well as pointing out the cross-cultural issues in communication that face all doctors, they discuss the way illness is discussed in English, and how accessible this is for non-native speakers. For example, different languages and cultures exhibit politeness differently, power is understood differently and this all plays into the communication between doctors and patients. Again they point to the lack of research on non-native speakers, though their own experience is that many of those referred to them with communication problems fall into that category. They give a number of reasons why this may be the case: being relatively new arrivals and not having had time to learn and understand the culture; being more abrupt than is usual in the UK context; not understanding everything in detail, which has potential consequences for treating patients.

San Miguel, Rogan, Kilstoff and Brown (2006)'s study of first year nursing students from non-English speaking backgrounds in Australia, who had not reached the required grade in interpersonal skills, highlights other problems: interpreting colloquialisms, accents or styles of speaking and understanding instructions. Problems the students identified themselves before attending training also included: difficulties in introducing themselves to patients, understanding patient comments, requests, giving instructions and talking to more senior

staff, particularly asking for clarification. An issue facilitators raised was the need to learn 'small talk' and to decide what could be talked about in small talk with patients. Other problems that surfaced were around appropriate use of body language, dealing with medical terminology, as well as more personal feelings of being cut off or lonely as a result of language difficulties.

One point worth noting in this study was the use of a mix of a language and linguistic specialist alongside nursing academics in designing and running the programme. The student nurses spent time learning set expressions for particular points in the communication, like taking leave of a patient; topics and ideas for small talk and more informal ways of phrasing medical issues and colloquial phrases that patients were likely to use.

Within each profession and speciality there are also likely to be particular ways of using language. Lu and Maithus (2012) look at issues facing clinical tutors of English as an Additional Language (EAL) students in New Zealand, in particular focusing on the language of nursing and underlying cultural rules that the students need to learn. In this article, they point to the need for training for supervisors in the workplace who need to support students. One important conclusion in this study is that there is a link between levels of knowledge and theory and how well the students were able to communicate, to the development of positive relationships with patients, and how responsive they were to feedback.

This section has focused so far on those who do not have English as a first language. However, it is important to note that there is evidence also of differences between UK trainees of different ethnicities, which include their approaches to consultations (see for example Woolf, Potts and McManus 2011). There are also the challenges for all health professionals in dealing with cross cultural issues more generally.

10.2 Cross-cultural issues within communication

In relation to these cross-cultural issues there are debates around what to include in communication skills courses or clinical education more widely, and how to do it. Skelton et al (2001) pose a number of questions around whether the following should be included: information about the expectations of different cultural groups, information about cultural specific issues (such as specific important religious events), or whether there should be a focus on generic skills that are transferable.

The difficulty for those designing and running communication skills (and other healthcare) courses is of avoiding stereotyping and 'essentialising' particular ethnic or cultural groups and therefore particular patients (Sears 2012). Sears (2012) argues that there is not a lot of evidence that cross cultural education interventions have an impact. The problems she identifies are 'simplistic cultural prescriptions' about particular racial/ ethnic groups and a lack of recognition that people from particular groups are not the same. There are other factors which influence and individual's health and how they view it, such as gender, age,

social class etc. In response to the desire to include consideration of cultural issues in training, she proposes an 'intersectional framework'. This means training doctors, and others, to consider what assumptions come together in dealing with patients "that are politically, economically, educationally, sexually, culturally and /or otherwise marginalised within a larger societal context' (p46). Her basic point is that patients have 'multiple vulnerability' and that considering only one aspect of their context is not sufficiently patient-centred. In terms of applying this in training she recommends doctors thinking about how these factors influence their own perspectives so that they are open to the idea of this intersectionality. She argues that this helps doctors identify commonalities with different patients and therefore develop a greater understanding of how to interact. She recommends the RESPECT model: 'engendering Respect, employing an Explanatory model, identifying Social context, equalising Power, employing Empathy, eliciting Concerns and engendering Trust' (Sears 2012:549). There are those who would argue that part of the issue is the focusing on the 'cultural competence' of healthcare professionals, when the focus should be on 'cultural humility' (Tervalon et al 1998).

It is also worth asking whether or not healthcare professionals see culture as part of their difficulties with communication. Fallowfield et al (1998) note that doctors on a particular training programme associated some of the difficulties they felt with culture and ethnicity. One example of a study looking at communication with Black Minority Ethnic (BME) patients focuses on patients with sickle cell disease (Thomas and Cohn 2006). This study looks at a programme for healthcare workers from a range of relevant professions and it focused on communication and cultural awareness. There was evidence of improvement in communication with patients at 3 and 6 months post-course. One key aspect of the course was a focus on barriers within the individual professional to empathy with patients. There is a potential danger in such an approach, as patients from a particular group can be labelled as difficult, resulting in the sort of responses Sears (2012) warns about.

11. Training of communication skills teachers

Although the training of communication skills teachers was not initially part of the aims of this review, it is an important consideration in the design of communication skills courses. There is not a great deal discussed in the literature, but there are some points worth noting.

The first is that the teachers of communication skills need to go through a similar process to the learners on their courses, of practising and receiving feedback (Aspegren 1999) and that the same principles should apply (Noble and Richardson 2006). Instructional approaches are not sufficient. This is the approach taken in Bylund, Brown, de Ciccone, Levin, Guegen, Hill and Kissane's (2008) study of a training course for 33 doctors on how to facilitate communication skills workshops. They found that one of the main challenges is to train clinicians to help other clinicians develop a range of communication skills. It is in the facilitation of feedback that the skill of the teacher is tested. They need to learn to avoid criticising learners and instead help them to reflect and identify strengths and areas to work

on. There is also a need they identified to consider co-facilitation as most communication workshops are run by more than one facilitator and consistency of approach is important, particularly if any assessment of learners takes place. They recommend a set of guidelines for facilitators and also training for facilitators in managing 'critical incidents' that might occur during training.

12. Conclusion

From the literature reviewed here, it is clear that communication skills teaching is an important area of work, which has been greatly researched. There is much evidence of what works, what the challenges are. There are debates about approaches, but also a great deal of consensus and there are numerous models and approaches with common elements that can inform the design and delivery of communication skills courses. There are gaps in the literature, not least on inter-professional learning and also in relation to the specific requirements of healthcare professionals who have studied abroad. Both these areas are increasingly of importance. There is also a need for more detail on the theories of learning that underpin approaches to communication skills teaching and consideration of what theories of workplace learning have to offer, particularly in relation to retention of skills. However, there is certainly sufficient written to indicate the degree to which courses provided by the PSU are in line with what is recommended in the literature, and provide ideas for the continuing development of communication skills teaching provision.

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