

Communications Skills Training

State of the art

A portrait of Ellen Smets, a woman with dark, curly hair, wearing a blue top and a necklace. She is looking slightly to the right of the camera. The background is a blurred industrial or laboratory setting with metal structures and lights.

Ellen Smets



Social
Psychologist

Ellen Smets



Social
Psychologist

Ellen Smets

4 years
older
now

Department
Medical
psychology





Research
Information
provision

Oncology
Genetics
Dementia

Medical
specialists



Teach
Medical students



*Medicine is a delicate
balance of art, science
and communication*

Dutch Health Counsel



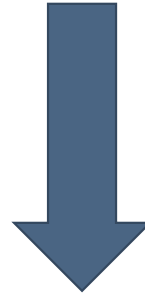
Assumptions

Communication skills

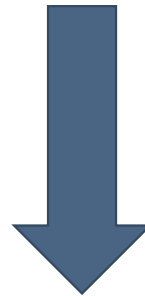
- can not be compensated for by strong interpersonal skills
- can be improved by training, they are not inborn qualities
- are relevant for patient-outcomes,
e.g. recall of relevant information, sense of control, less distress, adherence, better health
- are relevant for clinician outcomes,
e.g. job satisfaction, emotional burnout



Communication skills training



Better communication skills



Improved patient/physician outcomes



Communications Skills Training

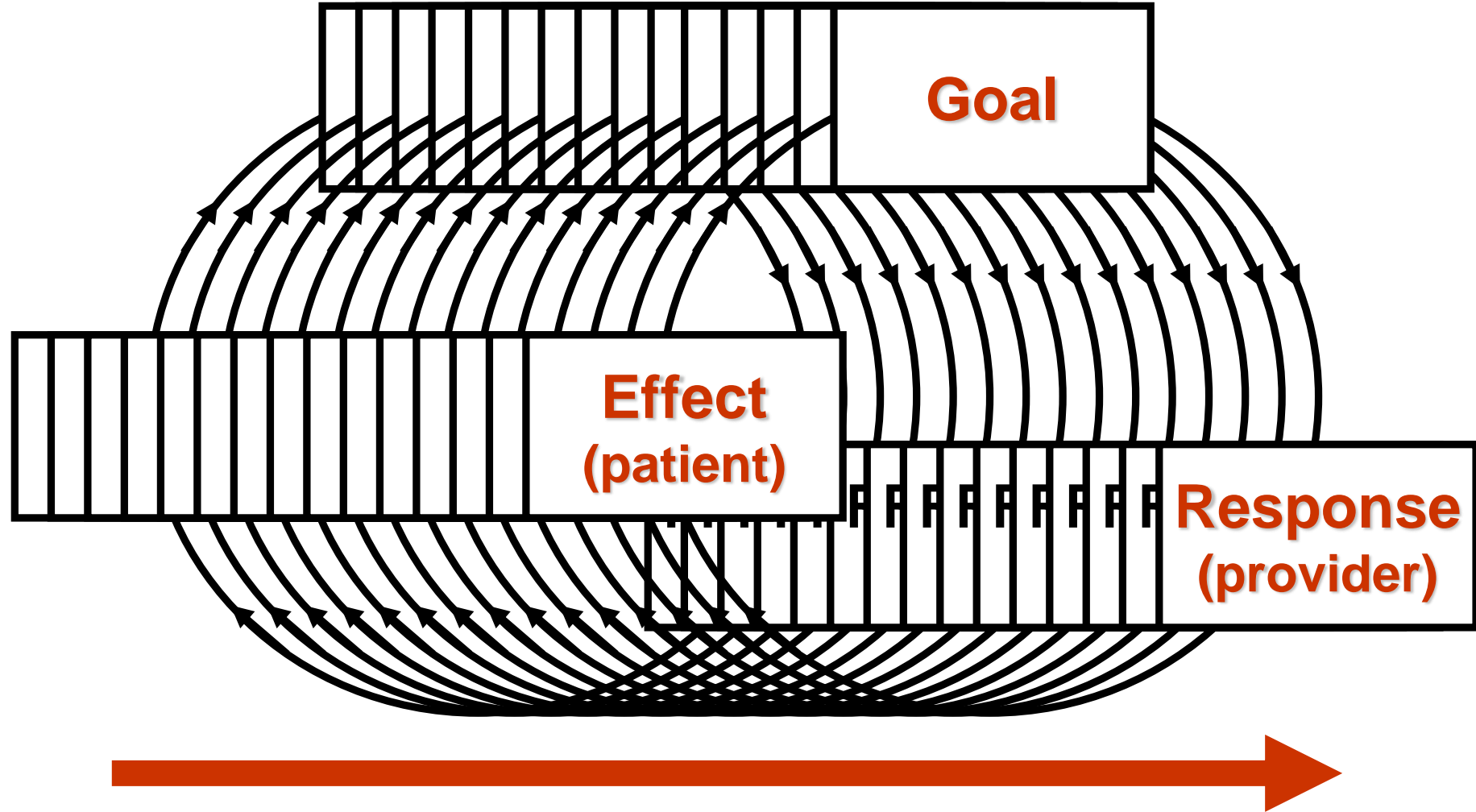
1. Education
2. Research
 - trial
 - review

Communications Skills Training

1. Education



Goal oriented behaviour



Time

Hulsman, PEC, 2009



Goals pursued

6 Functions of medical communication

	Six functions	Professional goals / effects
1	Fostering the relationship	Effective relationship = cooperation
2	Gathering information	Adequate diagnosis & interpretation of symptoms
3	Providing information	Well informed patient
4	Decision making	Reaching effective and preferred decision
5	Enabling disease & treatment related behavior	Adequate and feasible disease & treatment related patient behavior
6	Responding to emotions	Effective communication; support for patient; referral if needed



Medical Education

undergraduate

	Six functions	
1	Fostering the relationship	First year (basic skills – trust)
2	Gathering information	First year (medical interview)
3	Providing information	Second year (treatment information, bad news)
4	Decision making	Third year (shared decision making)
5	Enabling disease & treatment related behavior	Fourth year (motivational interviewing)
6	Responding to emotions	Fourth year (aggressive patients, discussing end of life)



**Medical
Education**
undergraduate

- Small groups (6-12 students)
- Two-hours
- Simulated patients
- Scenario based
- Structured peer feedback
- Video-recording
- Formal assessment (medical interview, SDM)



Medical Education

postgraduate

- Shared decision making
- Genetic counseling
- Communicating prognosis with numbers (in prep.)
- Communicating uncertainty (in prep.)

Communications Skills Training

1. Education
2. Research

Communications Skills Training

1. Education
2. Research
- trial



Henselmans *et al.* *BMC Cancer* (2018) 18:55
DOI 10.1186/s12885-017-3838-8

BMC Cancer

STUDY PROTOCOL

Open Access



A randomized controlled trial of a skills training for oncologists and a communication aid for patients to stimulate shared decision making about palliative systemic treatment (CHOICE): study protocol


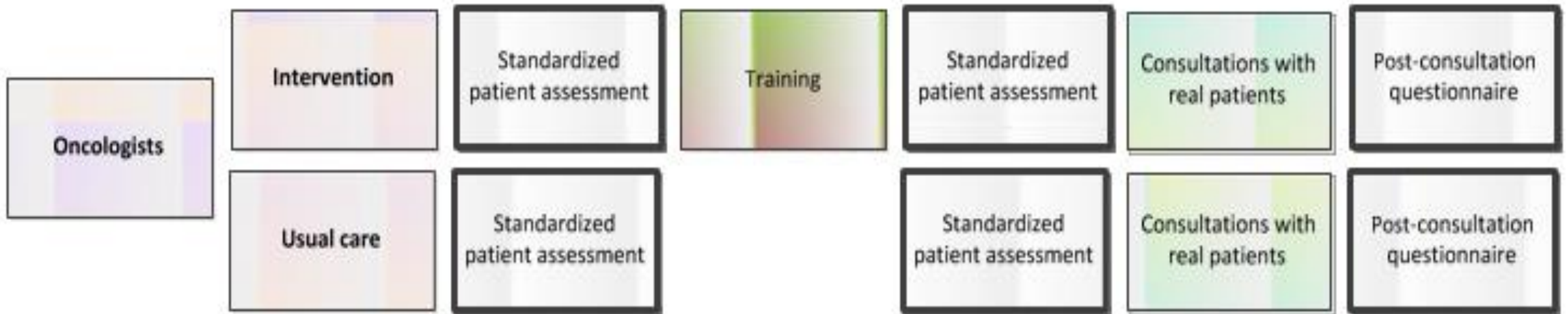
I. Henselmans^{1*} , E. M. A. Smets¹, J. C. J. M. de Haes¹, M. G. W. Dijkgraaf², F. Y. de Vos³ and H. W. M. van Laarhoven⁴





Figure 1. Design over time.



Oncologists n=31

Patients (median life expectancy < 12 months) n=194



The training

- based on a four-stage SDM model*
- reader, two group sessions (3.5 hours each), booster session (1.5 hours), consultation card



Results

Simulated
consultations



The training

- based on a four-stage SDM model*
- reader, two group sessions (3.5 hours each), booster session (1.5 hours), consultation card



Significant and large effect on observed SDM in the simulated consultations

Improved observed SDM behavior in all four SDM stages

Improved oncologists'

- information provision skills
- skills related to anticipating/responding to emotions
- satisfaction with the consultation

Results

Simulated consultations



Results

Clinical consultations

Large positive effect on observed SDM (OPTION12)
On all individual SDM steps
and on patient-reported SDM

No effect on patient or oncologist satisfaction with the consultation nor
patients' decisional conflict

No effect on consultation duration or the decision made





Communications Skills Training

1. Education
2. Research
 - trial
 - review



Communication skills training for healthcare professionals in oncology over the past decade: a systematic review of reviews

*Danique W. Bos – van den Hoek^{a,b,c}, Leonie N.C. Visser^{a,b,d},
Richard F. Brown^e, Ellen M.A. Smets^{a,b,c}, and Inge Henselmans^{a,b,c}*

Purpose of review

Effective communication in cancer care requires complex communication skills of healthcare professionals (HCPs), which can be advanced by communication skills training (CST). The number of empirical studies on CST has grown steadily over the last decade. However, controversies on CST abound. The aim of this

Review of reviews



AIMS

1. To summarize evidence on the **effectiveness** of CST
2. To summarize **effective features** of CST
3. Synthesize **current opinions**



Method

- 9 papers included (out of 3049)
- 3 key reviews:
 - Moore et al. 2018 - Cochrane meta-analysis
 - Barth and Lannen 2011 - meta-analysis
 - Uitterhoeve et al. 2010 - review



Method

- **Outcomes effectiveness***:
 - **Reaction** to training
 - **Learning** - self reported or observed behavior in simulated setting
 - **Behavior** - behavior in clinical setting
 - **Results** - impact on patient outcomes

- **Outcomes features**:
 - **Intensity**- frequency
 - **Format** - method e.g. role play
 - **Content**- specific skills

* Kirckpatrick Train Dev 1996



1. Effectiveness

- 1/3 studies in simulated setting, 1/3 clinical setting, 1/3 in both
- Behavior: evidence for positive effect on communication skills, evidence is limited
- Results: no demonstrated effect on patient outcomes
 - Evidence scarce and inconsistent
 - High heterogeneity in types of CST, patients, outcomes assessed, tools used
 - Short term perspective



Remains unknown

- Intensity

- Range 2 - 105 hours
- Barth and Lannen: trend for > 24 hrs to be more effective
- Position papers and guidelines* nevertheless adopt 3 day criterion

- Format

- Guidelines* recommend role play, real/simulated patients, structured feedback
- Too much diversity
- No comparison studies

- Content

- Not addressed

Gilligan et al 2017; Stiefel et al. 2010, 2017

2. Effect of features



3. Current opinions

- Use predefined primary outcomes
- Use conceptual frameworks to help organize and explicate skills and accurate assessment (match of training goals and outcome measurement)
- Investigate effective components, taking into account that these may differ for different skills
- Investigate effect on patient outcomes
- Investigate cost-effectiveness



Points of debate

- Communication as a set of skills is reductionist and mistaken. Discrete observable skills may not take into account the complexity of interactions, the authenticity and creativity required

e.g. Salmon & Young, 2011

- Breaking communication in its discrete parts may allow a learner to appreciate what is required, to gain proficiency and be able to use skills more flexible, creatively

e.g. Deveugele, 2015





Points of debate

- Quality of CST trainers / train the trainers has only rarely been focus of research
- Trainers should be health care professionals themselves

e.g. Stiefel et al., 2010, 2017

- Mandatory versus voluntary
- Tailored to personal learning needs versus feasible

e.g. Libert et al.





Points of debate

- Papers do not report theoretical perspective of their work - most common patient -centered care
- No co-creation, involving providers and/or patients
- Focus on behavioural learning outcomes, rather than also on knowledge and awareness/reflective outcomes



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