H - Com

"Framework for health communication needs and training methodologies"

Literature Review Report

Health Communication Training for Health Professionals

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This report has been developed by the consortium of the Health Communication Training for Health Professionals Project

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The H-Com partnership comprises 6 partners from 5 countries

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The H-Com project is co-funded by the Erasmus+ Programme of the European Union

Co-funded by the Erasmus+ Programme of the European Union

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Acknowledgements:

The authors would like to thank the following experts for preparing the country reports as well as for their contribution to the overall compilation of the current report:

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Introduction

The European co-funded Erasmus+ project H-COM aims to develop a comprehensive training curriculum which will be easily replicated across the EU. The aim of this training is to build and strengthen communication skills among health professionals, with a focus on medical doctors and nurses, which will positively influence their work with their patients and their coworkers within the health care setting.

The H-COM Project aims, among others, to thoroughly analyze and present the situation concerning health communication in a comprehensive state-of-the-art report. This output is scheduled to be achieved through **(1) participatory research – focus groups**, **(2) an online survey**, and **(3) this in-depth literature review**.

The present report presents the findings from the literature review conducted both at country level (consortium countries) and at international level through the scientific and grey literature reviews.

Type:	Development
Work method:	Research, search, research grid and guidelines, State of the Art reports
Work package title:	Framework for health communication needs and training methodologies
Starting month:	September 2015
Duration:	12 months
Ending:	August 2016
Lead partner:	Lodz (Poland) - Nofer Institute of Occupational Medicine
Activity Leading Partner:	Athens (Greece) - Institute of Preventive Medicine Environmental & Occupational Health, Prolepsis

Defining Health Communication

In an article published by the Bulletin of the World Health Organization in 2009, the importance of communication is highlighted by noting that it is "at the heart of who we are as human beings" (Rimal & Lapinski, 2009).

According to Carey (2008), communication can be defined as the symbolic exchange of shared meaning, and it has in itself a dualistic role. On the one hand, there is the transmission component, which reflects the essential parts of the communication process, which are the channel, the source, the receiver, and the message. On the other hand, the ritualistic component conceptualizes target audiences as members of social networks who interact with one another, engage in social ceremony, and derive meaning from the enactment of habitual behaviors (Carey, 2008; Rimal & Lapinski, 2009).

Health communication gained recognition as an integral part of public health in the USA Healthy People's 2010 objectives where it was seen to have relevance for all aspects of health and well-being, including disease prevention, health promotion and quality of life (Rimal & Lapinski, 2009; Witte, 1994).

According to *Healthy People 2010,* health communication includes the study and use of communication strategies to inform and influence individual and community decisions that enhance health (DHHS, 2001). It actually connects the fields of communication and health and is increasingly viewed as a *sine qua non* part of every effort aimed at improving individual or public health (DHHS, 2001; Rimal & Lapinski, 2009; CDC, 2011; Bernhardt, 2004; Guide to Community Preventive Services, 2010; NCI, 1989; Piotrow, Kincaid, Rimon & Rhinehart, 1997; Jackson & Duffy, 1998).

Health communication can contribute to all aspects of disease prevention and health promotion and is relevant in a number of contexts, including:

- Health professional-patient relations
- Individuals' exposure to, search for, and use of health information
- Individuals' adherence to clinical recommendations and regimens
- The construction of public health messages and campaigns
- The dissemination of individual and population health risk information (risk communication)
- Images of health in the mass media and the culture at large
- The education of consumers about how to gain access to the public health and health care systems, and
- The development of telehealth applications

(DHHS, 2001; Jackson & Duffy, 1998; Eng & Gustafson, 1999; Northouse & Northouse, 1992; Maibach & Parrott, 1995; Ray & Donohew, 1990; Freimuth, Stein & Kean, 1989; Atkin & Wallack, 1990; Backer, Rogers & Sopory, 1992; Harris, 2013).

The Centers for Disease Control and Prevention (CDC) and the National Cancer Institute have defined health communication as the study and use of communication strategies to inform and influence individual decisions that enhance health (CDC, 2011).

In addition to defining health communication, the CDC tries to connect it with social marketing by underlining their common goal, which is to create social change by changing people's attitudes, external structures, and by modifying or eliminating certain behaviors. In this context, the term "health marketing" is introduced as a blending of multiple disciplines: the theoretical underpinnings of social marketing with the outreach communication strategies used in health communication (CDC, 2011).

In an editorial in the *American Journal of Public Health,* Bernhardt underlines the emerging role of public health communication, taking under consideration the fact that both science and communication are essential in promoting and protecting the health of the public (Bernhardt, 2004). The Institute of Medicine also stresses the importance of health communication within the contexts of evidence-based medicine which defines public health as what we – as a society – do collectively to assure the conditions in which people can be healthy (Gebbie, Rosenstock & Hernandez, 2003; Institute of Medicine, 2002; Institute of Medicine, 2003). Thus, Bernhardt defines public health communication as the scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable health information communicated to and from intended audiences to advance the health of the public.

Focusing on the doctor-patient relationship - The H-COM Approach

As mentioned earlier in this literature review, health communication can be generally defined as the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues.

Taking into consideration the wide range and variety of topics that can be addressed under this general definition, the H-COM Project will mostly focus on the crucial role that health communication can play in improving the relationship between the health professional (eg. medical doctor, nurse, etc.) and the patient. The formation of a sound and trusting relationship between the health professional and the patient has always been considered to be extremely important for every aspect of medical and paramedical practice.

Good health provider-patient communication contributes to quality care and improved health status (DHHS, 2000). Especially at the clinical level, effective communication underpins prevention and screening efforts, when providers have the opportunity to engage in one-on-one counselling and supply information that is culturally and linguistically appropriate and delivered considering the patient's health literacy level. The differential diagnosis procedure, the diagnostic laboratory and imaging workup, and the treatment or management plan require doctors to negotiate a common understanding with patients about what is to be done.

Furthermore, the quality of provider-patient communication can affect numerous outcomes, including patient adherence to recommendations and health status. Appropriate information and communication with a health professional can not only relieve patients' anxieties, but also help patients understand their choices, allow them to participate in informed decision-making, and better manage their own health concerns (DHHS, 2000; Ong, De Haes, Hoos & Lammes, 1995).

Chapter 1: The importance of health communication for the doctor/nurse – patient relationship

Over the past decades, the importance of health professional – patient communication has become an increasingly important topic among the scientific community. This communication is an integral part of clinical practice, as it constitutes a core clinical skill and the building block upon which the physician's relationship with the patient is based (Nelson, 2008). The way the physician communicates information to the patient is equally important as the actual information being communicated. Promoting the patients' health, while providing them with the best available medical care, is a crucial feature of the communication between health professionals and patients. The main goals of this communication are to build upon the provider – patient relationship, foster a working alliance between them and, at the same time, include the patient in the decision making process regarding their health (Ha & Longnecker, 2010; Arora, 2003; Elwyn et al., 2012). Care providers utilize their communication skills during the medical interview to take the patients' history, during consultation to provide clarification and answers to patients' concerns about their health and to, in general, offer counsel and guide the patients throughout the course of their treatment (Coulehan & Block, 2006; Duffy, Gordon, Whelan, Cole-Kelly, & Frankel, 2004).

The Doctor – Patient Relationship

An extensive body of literature has examined the quality of the doctor – patient communication and its effects on their relationship (Corrigan, 2005; Pires & Cavaco, 2014; Shukla, Yadav & Kastury, 2010; Stewart, 2005). Until the first half of the 20th century, doctors would primarily follow a more 'medical model' to treatment, where their most prominent concern was on how to utilize their expertise in order to treat a disease and inform the patient on which therapeutic plan they should follow (Kurtz, 2002). In this process, the doctor was viewed as a powerful figure and the patient as a passive recipient of the health professional's proficiency on how to best cure their health condition without any input or objections (Krupat et al. 2000). Since then, the focus has been shifting into a more 'patient centered' approach, where the person is the focal point of treatment (Levinson, Lesser & Epstein, 2010; Mead & Bower, 2000). The doctor forms a working relationship with the patients, listens to their input and concerns, engages with them on an emotional level and reaches a better understanding of their situation.

Specific communication skills and competences that doctors exhibit during their contact with patients have been the focus of extensive research (Hack, Degner & Parker, 2005; Harrington, Noble & Newman, 2004). The most prominent skill deals with the matter of information giving behaviors (Shaw et al. 2009). In the case of health care, doctors are the designated person to

thoroughly provide clarification and specific information to the patients about their health condition, prognosis, therapeutic plans and options, outcomes and possible adverse events. The way this information is communicated plays a major role in the doctor – patient relationship. Patients are usually not familiar with the medical vocabulary that doctors utilize and find themselves in a position where they often do not fully understand the specifics of their disease and treatment. Doctors who go into great detail when talking with patients about their disease, employ an everyday language free from medical jargon, take the time to clearly explain the aspects of the disease and treatment plan, answer the patients' questions and make sure they have understood what was said, are able to form a superior relationship with their patients.

Another skill, which is closely connected to information giving, is empathy (Charon, 2001; Pedersen, 2009). Patients who receive information about their disease, particularly in the cases of bad news or negative outcomes, are often under a great amount of stress. They argue that doctors, who prompt them to talk about their worries and feelings of anxiety, can alleviate these concerns. They appreciate being heard and acknowledged by their physicians and feel more satisfied with their care.

The Nurse – Patient Relationship

The scientific community has also been exploring the nature of the nurse-patient communication. Nurses are generally viewed by society as taking on the role of a caretaker or someone who engages personally with a patient, in order to provide comfort and reassurance to them (Fealy, 2004; Shattell, 2004). When patients find themselves in an unfamiliar setting, such as a hospital ward or a nursing home, where their health status has been jeopardized and are unable to care for themselves, they tend to feel apprehensive and increasingly concerned about their health condition. By communicating with patients who are in such a vulnerable and dependent state, nurses can play a significant role in helping relieve their stress and worries and promote their wellbeing (Epstein & Street, 2007; Kettunen, Poskiparta & Liimatainen, 2001).

The scientific literature has focused on identifying the skills that nurses employ when communicating with their patients (McCabe, 2004; Shattell, 2004; Nairn, 2004; Fleischer et al., 2009). One of the most commonly reported communication skills of nurses is empathy, which is associated with the emotional engagement between them and the patient. Empathy is a crucial aspect of communication, as it allows the person to connect with another and gain a better understanding of their emotions and concerns and, as such, can help nurses improve the quality of care they provide to their patients (Morse et al., 2006; Kirk, 2007). Patients argue that nurses, who communicate in a warm and considerate manner, while being able to adapt to each situation and their different needs, make them feel appreciated and valued as individuals. In these cases, patients perceive a sense of safety and acceptance and tend to provide more information about their health conditions, which can have a positive effect on their clinical diagnosis and prognosis. Through this, nurses can achieve a better working relationship with their patients (Klein, 2005).

Another skill that nurses employ is the ability to 'listen to the patient' and respond to their cues (Kruijver, Kerkstra, Bensing, & Van De Wiel, 2001; Uitterhoeve et al., 2009). Studies have shown that nurses, who pay attention to what the patients are saying, acknowledge their concerns

about their health and respect their requests, can help patients feel more comfortable during their stay at the hospital. A good sense of humor has also been identified as a communication skill of nurses (Greenberg, 2003; McCabe, 2004; Morse et al., 2006). Nurses who talk in a friendly manner and utilize humor when interacting with patients, help relieve their stress and anxiety levels by providing some form of distraction from the mundane process of hospitalization and the concerns about their health.

Effects of Provider – Patient Communication on Outcomes

It has been argued that, a more 'patient-centered' approach (Oates, Weston & Jordan, 2000) in the doctor – patient communication has the potential to promote the health outcomes of patients (Di Blasi, Harkness, Ernst, Georgiou & Kleijnen, 2001; Jahng, Martin, Golin, & DiMatteo, 2005; Street, Makoul, Arora, & Epstein, 2009). Communication between health professionals and patients can be grouped in two broad categories: a) communication focused on the medical aspect of health (e.g. information on the disease and treatment plan) and b) communication focused on the person (e.g. listening to the patients' input and concerns, providing reassurance and involving patients in the decision making process) (Epstein et al., 2005; Zachariae et al., 2003).

There is extensive scientific evidence demonstrating that patients, who communicate effectively with their doctors and nurses, are more likely to acknowledge their health problems, have a clearer understanding of their treatment options and plans, are more inclined to change their health behaviors and self-manage their health conditions, show more adherence to treatment and consistency with their medication and are more satisfied with the quality of health care they receive (Stewart, 1995; Parrot, 2004).

Adherence to Treatment

Patients' adherence to their treatment plan (e.g. following their medication uptake schedules, self-management of their disease, regular screenings) has been found to be affected by the level of provider-patient communication. Specifically, when health professionals go into great detail explaining the information about a specific medication or treatment to their patients (e.g. its nature and purpose, possible side effects, timeframe and schedule), employ a warm and friendly approach to their consultations and provide clear answer to their questions and concerns, their patients feel more inclined to follow their treatment plan (Jimmy & Rose, 2011; Thompson & McCabe, 2012).

In a meta-analysis of 127 studies, Zolnierek and DiMatteo (2009) found that good physician-patient communication improves patients' adherence to treatment by 19%, and in the cases where physicians received communication skills training, it improved by 12%. They found that the odds of a patient adhering to treatment were 2.16 times higher if there was good communication with the doctor, whereas the cases of nonadherence were 1.47 times higher if the communication was not satisfactory. Thompson and McCabe (2012) conducted a systematic review of the literature on the effects of clinician – patient 'alliance' on mental patients' adherence to treatment. In a therapy setting, establishing rapport and good, collaborative communication is of pivotal importance for the outcomes of treatment (Leach, 2005). The reviewed studies consistently showed that, clinicians who employed a non-judgmental approach

to their consultation, had a friendly and optimistic manner of communicating and explained in detail the therapeutic plan and process, were found to have more patients who adhered to their treatment over time.

Hospital Readmission

Hospital readmissions have also been found to be affected by the communication between health professionals and patients. In the cases where patients experience post-discharge adverse events, which often lead to readmission, they commonly argue that the health care professionals either did not provide them with adequate information about their treatment plan, or they would overwhelm them with information in a not clearly understood way (Coleman & Berenson, 2004; Epstein, 2009; Kripalani et al., 2010; Pearson, Skelly, Wileman, & Masud, 2002).

Patients' adherence to treatment is closely linked with hospital readmissions (Doyle, Lennox & Bell, 2013; Sun, Liu, Christensen, & Fu, 2007). Since patients need to have a clear understanding of their health condition and its effects on their health, as well as the therapeutic plan they need to follow, good communication with their doctors is required in order to prevent future unnecessary visitations to the hospital. Errors within the health care system, such as poor communication between medical staff and patients, have been found to account for 19-23% of patients experiencing an adverse event soon after discharge. More importantly, most of these events are thought to be preventable or ameliorable, where their severity or duration could have been reduced. Due to time restrictions and pressing workloads, hospital physicians tend to only briefly explain the medication regime that patients need to follow after hospitalization, without providing visual cues (e.g. detailed written list of daily drug intake), or by simply asking the patients whether they know what they need to do after discharge, without properly gauging their level of understanding (Forster et al. 2003; Kripalani et al., 2007).

Hospital readmission rates are also affected by the health literacy levels of patients (Safeer, & Keenan, 2005; Schillinger, Bindman, Wang, Stewart & Piette, 2004; Williams, Davis, Parker & Weiss, 2007). People with reduced ability to understand and process information about their health experience difficulties with adherence to their treatment plans and are often in need of hospitalization soon after discharge. Research has shown that physicians who employ a plain language when talking with patients, by avoiding medical jargon and unfamiliar words (e.g. 'active ingredients of medication'), have fewer patients readmitted within the first 30 days of discharge. In support of this finding, Lindholm et al. (2012) conducted a study where professional language interpreters were trained in medical interpretation and employed in several US hospitals. They helped patients with limited proficiency in English and health literacy understand the specifics of their condition and their physicians' recommendations, during their stay at the hospital. At the end of the study, patients who received this interpretation stayed for a shorter period in the hospital, and were less likely to be readmitted within the first 30 days following discharge, than those who did not receive this interpretation.

Patient Satisfaction

Good health professional – patient communication has been found to have a positive effect on patients' satisfaction with the quality of health care they receive. Health professionals who are

able to communicate effectively with their colleagues, as well as offer a personalized care approach by employing a warm and friendly tone during their consultations, help improve the quality of provided health care, and to an extent, patients' satisfaction (Coulter & Ellins, 2007; de Haes & Teunissen, 2005; Ervin, 2006; Leonard, Graham, & Bonacum, 2004).

In an intervention study by Nørgaard et al. (2012), health professionals of the Department of Orthopaedic Surgery, Kolding Hospital, Denmark, received a communications skill-training course between February 2008 and April 2009. Researchers found that, patients reported feeling more satisfied with the quality of care they received after health professionals had attended the communication training sessions. Patients also expressed to be more satisfied with the care they received from their nurses and nursing assistants who completed the training program. In a study by Street, Gordon and Haidet (2007), the doctor – patient communication and its effects on quality of care were examined. Physicians were found to communicate better and had a more effective relationship with patients who showed an interest in their treatment. Their findings showed that, patients who asked questions, shared their concerns and, in general, were actively engaged with their therapeutic plan, were more positively regarded by physicians. Their interest allows doctors to provide clear explanations about their health condition, prognosis and treatment options, while being more supportive during their consultations. Patients also reported that they were more satisfied with their care whenever their emotional needs were met, particularly when their doctor's utilized a more patient-centered approach and paid attention to their requests.

Information from the Media and provider – patient relationship

Over the past decades, the use of the Internet has become part of everyday life, with millions of people looking up health related information daily. In 2010, a US survey found that 74% of internet users look up information online about diseases, medication, treatment plans, reviews of doctors and other patients' experiences of similar health conditions (Fox, 2011). Studies have shown that as patients find information about their health online, their relationship with their health care providers can be affected in different ways (Andreassen et al., 2006; Broom, 2005; Diaz et al. 2002; McMullan, 2006). The most prominent feature is that, accessing a plethora of information provides the patients with a sense of control over their disease and allows them to become more actively engaged with their treatment. In this case, patients claim to feel more satisfied when talking with their doctors, as they can communicate on a better level, due to the presence of pre-existing knowledge about their condition and treatment options.

On the other hand, concerns have been raised that the doctor – patient relationship can be negatively impacted by accessing information online. Doctors, especially those who are not comfortable with using the Internet, may feel irritated with their informed patients. They may perceive the patients' involvement and opinions as challenging their expertise and knowledge. They may then react by disregarding their input and adopting a more distanced approach during consultation, without involving the patient in the decision making process (Hart, Henwood & Wyatt, 2004).

Chapter 2: Needs, obstacles and perceptions of health professionals and patients regarding health communication

This section describes the extent to which health care professionals in particular doctors and nurses possess the necessary skills to practice health communication and the extent to which they are taught these skills at the various stages of their formal and informal training. The section also presents obstacles and perceptions of health care professionals in terms of health communication.

The Medical School Environment

Health communication training in medical and nursing schools differs between EU countries. Based on the results form a mapping of available health communication training opportunities across the EU conducted by the H-COM consortium some EU contries like the UK and Germany have invested in health communication training making its study part of the regular medical or nursing curriculum. Other countries such as Greece, Cyprus and Poland for example emphasise health communication during medical training less, making relevant modules non compulsory.

The USA and Canada as opposed to the EU has made health communication an integral part of medical curriculum and physicians are examined in health communication to obtain their medical licence (King & Hoppe, 2013; Zolnierek & DiMatteo). Travaline et al. (2005) mention that 65% of medical schools in the USA teach communication skills while health communication is part of the American Licensing examination.

Formal medical training has contributed to the communication gap beyond the mere exclusion of coursework emphasizing communication (Hojat, Vergare, Maxwell, Brainard, Herrine, Isenberg, Veloski, & Gonnella, 2009). Furthermore, there is evidence that medical school as a competitive, tiring, and emotionally strenuous environment emphasizes procedural knowledge and discourages empathy, ultimately affecting the provider's demeanor toward their patient (Ha, Anat, & Longnecker, 2010; Hojat et al. 2009). Modern medical education promotes emotional detachment and affective distance in order to preserve clinical neutrality, and in doing so forgets the importance of patient care (Coulehan & Williams, 2001). A large synthesis and analysis of unique studies from the US, UK, and Poland indicated that empathy declines significantly on entering the clinical practice phase of the curriculum as contact with patients increased, likely due to heightened feelings of vulnerability upon encountering morbidity and mortality first hand coupled with lack of social and emotional support via their educational institutions (Neumann et al., 2011). A secondary analysis of video-recorded medical consultations in the Netherlands from 1986 and 2002 determined that 2002 physicians were less engaged in partnership building with their patients: they were less likely to ask for patients' opinions or clarification of patients' words, and expressed less concern for their patients' medical condition (Bensing, Tromp, van Dulmen, van den Brink-Muinen, Verheul, & Schellevis, 2006). This deterioration of empathy critically widens the doctor-patient communication gap; communication skills alone are not enough to establish therapeutic care (Ha et al., 2010). Instead, the foundations of successful interpersonal communications between patient and provider require shared perceptions and

feelings regarding the nature of the problem, treatment goals, and psychosocial support (Duffy, Gordon, Whelan Cole-Kelly & Frankel, 2004).

Communicating Difficult Diagnoses

It is also of note that certain areas of specialized treatment have been identified as particularly unaddressed in the patient communication curricula that are available to medical students during their formal training. Specializations in which communication shortages have been identified include geriatric medicine, sexual disease clinics, cancer care, and uncommunicative intensive care units (Chant, Jenkinson, Randle, & Russell, 2002). These particular fields require extra dexterity with regards to communication, as physicians will often be confronted with issues of mortality or chronic illness. Often, physicians are poorly equipped to handle situations of such high levels of emotional intensity, and consequently become avoidant and do not engage in adequate communication techniques (Ha, Anat & Longnecker, 2010; Ferraton-Rollin et. al, 2013). This avoidant behavior is multilayered. A French qualitative study of cancer patients indicated that physician may fear that delivering the negative diagnosis may negatively influence the patient's mood beyond their emotional capacity, impact the family negatively, and ultimately create additional stress the patient and support system are not able to handle (Bettevy, Dufranc & Hoffman 2006). Maguire and Picthealy (2002) also note that physicians may engage in this avoidant behavior with difficult diagnoses as a means of self-preservation and their own emotional survival. These avoidant behaviors ultimately have an additional negative impact, as the patient perceives the interaction as unempathetic, and in return does not feel comfortable disclosing important information about the progression of their disease (Moore, Wilkinson & Rivera Mercado, 2004). As a result, there is indication for critical focus on the communication of serious and terminal diagnoses for patients during medical training.

Time

Lack of time and competing priorities during a medical visit was a repeated theme cited throughout the literature as a barrier to patient-provider communication (Alexander, Casalino, Tseng, McFadden, & Meltzer, 2004). Surveys have reported that while patients are satisfied with the care they receive through general practice, the length of the consultations are too short and time is not well managed (Deveugele, Derese, van den Brink-Muinen, Bensing, & De Maeseneer, 2002). This a sentiment also shared by medical providers. As one physician states in an article by Lussier & Richard (2006):

> As physicians, we often feel we are under pressure. In fact, we are compelled to manage our time very strictly. We are sometimes even overwhelmed by the demands patients make on us, particularly in these times, when there is a shortage of medical personnel. Given the circumstances, it is hardly surprising that doctors try different strategies to control consultation time. Lack of time is a constant preoccupation for doctors, and the feeling is shared by patients who consult them. (p. 1401)

This ultimately results in medical providers resorting to interview methods that are prohibitive to effective communication with their patients in the interest of time. Interrupting patients during interviews, as well as redirecting questions from the onset of the consultation becomes standard

practice, as providers fear losing control over the conversation and wasting time should the patient be allowed to answer freely (Lussier & Richard, 2006). This is despite a Swiss study indicating that approximately 77% of patients will speak for longer than two minutes if uninterrupted, and only 2% superseding five minute (Langewitz, Denz, Keller, Kiss, Rütimann, & Wössmer, 2002). This premature silencing of the patient during the consultation discourages patients from voicing the entirety of their medical concerns and asserting their need for additional information or explanation, ultimately resulting in poor understanding on behalf of the patient (Ha et al., 2010). A Dutch study examining medical consultations with hypertensive patients showed that one-third of patients in the study left the consultation with unanswered questions, with lack of time being the most frequently reported reason (Bensing et. al, 2006). According to Wilson & Childs (2002) physicians who have high-volume practices with shorter consultation times have higher rates of drug prescription, have a lesser focus on prevention and health-promotion activity, and reduces the execution of medicine as a holistic practice.

A major review examined the average consultation lengths of six European countries in an attempt to understand this particular barrier. Deveugele et al. (2002) noted that the mean length of a medical consultation was 10.7 minutes, with Germany and Spain having the shortest times (7.6 and 7.8 minutes, respectively) and Belgium and Switzerland having the longest (15.0 and 15.6 minutes, respectively). The study identified a number of factors that influenced the length of the consultation time: consults in urban areas lasted longer than their rural counterparts; they were longer if the problem of interest was new for the patient, if the patient was older, or if the problem was deemed to be psychosocial in nature; and most notably the visit time was reduced as the physician's workload increased (Deveugele et. al, 2002). Countries with the shortest consultation time (Spain and Germany) have greater workloads, with doctors seeing a mean of approximately 200 patients per week and could ultimately require a "culture" of shorter consultation times (Deveugele et. al, 2002). The same Deveugele et al. (2002) study indicates that Swiss and Belgian physicians operate in open market systems in which patients have the freedom to access multiple doctors and specialists and so healthcare workers have to invest more time in order to retain patients based off of greater patient satisfaction. In this case, we can determine that the allotted time a doctor has with a patient is influenced in part by the structure of that country's health system.

Cultural Competency

One of the most prominent barriers to provider-patient communication is the lack of cultural competency among doctors, nurses, and other healthcare workers. Cultural competence is defined as "the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences," and has been reported as an essential component of improving doctor-patient communication and consequent health outcomes (Smedley, Stith & Nelson, 2003). Higher rates of global movement have confronted healthcare providers with the need for additional, adequate levels of cultural competency in order to serve increasingly larger numbers of immigrant and minority populations (Hudelson, 2005). With these ever increasing demographic shifts, cultural competency is of utmost importance as research suggests that increasing culturally competence in health professionals would allow them to be more successful in making accurate diagnoses (Beach, Price, Gary, Robinson, Gozu, Palacio &

Powe, 2005). It is more common than ever for physicians to treat patients who differ in terms of language, illness-related beliefs and practices and healthcare expectations (Ferguson & Candib, 2002; Ryn, 2004; Van Ryn, Burgess, Malat, & Griffin, 2006). Hudelson's (2005) qualitative study of Swiss medical interpreters' opinions on communication barriers indicates three areas in which miscommunication is likely to occur: (1) ideas about the patient's health problem; (2) expectations of the clinical encounter; and (3) verbal and non-verbal communication styles. Interviews with interpreters indicated the necessity for awareness of potential sources of misunderstanding, some basic knowledge about patients' countries of origin (geography, politics, religion), and adaptation to patients' communication styles (Hudelson, 2005). Language barriers are particularly important, as patients who are not fluent in the language of their medical provider are less likely to elicit empathic responses from physicians, receive sufficient information, or be encouraged to participate in their medical autonomy (Ferguson & Candib, 2002). "Intermediate outcomes might ultimately impact patient outcomes considering that health care providers who are more knowledgeable about their patients' backgrounds, who have more positive attitudes towards their patients" (Beach et al., 2005).

This lack of competency can often perceived as racist or classist behavior, ultimately deterring patients from further interacting with their provider or adhering to medical treatment (Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008). Research that physicians associate negative attributes (non-compliance, less intelligent) with racial minorities, in particular (Street et al., 2007). The most common types of racism and classism reported by patients in a US study of African-American patients were feeling that a physician was not listening to their needs and that they were being treated with less respect than others (Hausmann, Hannon, Kresevic, Hanusa, Kwoh, & Ibrahim, 2011). Patients who perceive they are discriminated against by their providers are more likely to perceive future visits as negative, ultimately resulting higher rates of disengagement from care and decreased adherence to physician recommendations (Hausmann et al., 2011). This attitude, perceived as non-compliant and uncooperative, in turn, influences physician interactions with patients. A US study of physician interactions indicated that physicians were more contentious with patients whom they viewed as less effective communicators, thus perpetuating a mutually unfriendly interaction between provider and patient (Street, Gordon & Haidet, 2007). Ultimately, there is a communication impasse in which the mutuality of perception causes a breach in communication efforts. Because physicians' communication and perceptions are related to outcomes, it is necessary to account for variability in how medical providers relate to some patients versus others according to different demographic characteristics (Street et al., 2007). Biases toward a patient's demographic characteristics—gender, race, socio-economic class—reveal themselves in doctor-patient interactions despite the best intentions of the health provider (Burgess, Fu, & Van 2004). Hausmann et al. (2011) indicate that these are not conscious choices in behavior:

> The residual effects of discrimination occur outside of our awareness and therefore get communicated in subtle ways rather than through conscious verbal behavior. This is consistent with research showing that unconscious biases often get communicated through nonverbal, unintentional channels. (p.331)

As a result, it is critical that providers be educated about their own biases as well as the impact of past discriminatory behavior among minority or ethnically diverse populations in order to better understand communication needs among their patients (Burgess, Van Ryn, Dovidio, & Saha, 2007).

There is a lack of institutionalized promotion of cultural competency in medical training, since training at the individual level cannot succeed without institutional support and an over-all systematic change in how medicine is practiced (Brach & Fraserirector, 2000). Some suggestions for increasing cultural competency structurally include the use of interpreter services, recruiting and retaining a culturally diverse healthcare staff, as well as immersion programs for medical providers in-training (Brach & Fraserirector, 2000). While interpreter services are a widely used tool, and there are documented betterments in health outcomes associated with their usage, they are not perfect substitutes for culturally competent physicians (Rivadeneyra, Elderkin-Thompson, Silver, & Waitzkin, 2000). Studies suggest that a means of ameliorating this is by having a higher presence of healthcare providers that reflect the racial and ethnic demographics of their patient population, as this concordance may result in fewer discriminating practices (East & Peterson, 2000). According to Price et al. (2005), there are four concrete steps that can be taken to increase the diversity climate of the medical profession at the educational level: increasing leadership's awareness of their own attitudes and behavior, increasing institutional commitment to improving diversity, increasing diversity in institutional leadership, and increasing the number of faculty and staff who may identify with the diverse patient population.

Health Literacy

Health literacy-defined as, "the ability of citizens to make sound decisions concerning health in daily life at home, at work, in health care, at the market place and in the political arena"—is critically important to effective doctor-patient communication (Kickbusch & Maag, 2008; Ishikawa & Kiuchi, 2010). It has become the norm for patients to be active participants in the management of their own health and healthcare decisions, ultimately requiring patients to be well versed in how to interpret and apply the health information they receive (Kickbusch & Maag, 2008). Despite gaining recognition in the past several decades, particularly in the United States and Canada, as a matter of utmost importance with regards to healthcare policy, health literacy research in Europe is still fairly new (Pleasant, 2012; Sørensen, Van den Broucke, Fullam, Doyle, Pelikan, Slonska, & Brand, 2012). The research that has been conducted, however reflects that poor health literacy is linked to a number of negative health outcomes including poor understanding their own health, poorer comprehension of medical information, reduced understanding and use of preventative services, and over all poorer health status (Pleasant, 2012). "People in modern society are expected to actively engage in the management of their health and to make a wide range of health decisions. Sound health decisions require comprehensible health information that is accessible and appropriate to the needs and cultural and social backgrounds of individuals." (Kickbusch & Maag, 2008) Health literacy becomes a barrier to health communication in that patients with inadequate health literacy are not able to understand the content and importance of their interactions with medical providers, ultimately leading to reduced adherence of medical recommendations (IOM, 2011a)

Ishikawa & Kiuchi (2010) have described literacy as possessing skills beyond reading and writing, and including numeracy, listening capability, speaking, and the ability to apply cultural and conceptual knowledge. A study by Sørensen et al (2015), noted that there was great variability between the eight EU states with regards to health literacy levels, a difference of 6.56 points between the countries with the highest (the Netherlands) and lowest (Bulgaria) mean health literacy scores, with the standard deviation per country being wider in countries with lower reported rates of health literacy. The review identifies several factors that influenced the levels of health literacy across several demographics. This indicates inequity with regards to distribution of health literacy within each country's population. Health Literacy was noted to be more limited among people with generally poorer health status, low socio-economic status, lower general education, and older age (Sørensen et al., 2015). Health literacy was the most limited among those who self-reported their health as 'very bad' (78.1%) or 'bad' (71.8%), for those with more than one long-term illness (61%) and for those reporting six or more doctor visits in the last 12 months (58.9%) (Sørensen et al., 2015). "With regard to socio-economic status, higher proportions of people with limited health literacy are found among those whose social status is 'very low' (73.9%) or 'low' (60%), followed by those with the lowest or low levels of education (68 and 57.2%), those who have permanent problems paying bills (63.4%), and those who are between 66 and 75 years old (58.2%) or 76 years or older (60.8%). Again, there are marked differences between countries. In some countries, the proportions of people with limited health literacy often exceeded 75% for certain vulnerable groups, whereas in the Netherlands the proportions generally stayed below 50%."

Unfortunately, many medical offices are poorly equipped to cope with patients who have poor health literacy levels. Physicians often lack training in how to identify patients with low health literacy as well as do not have appropriate resources available in their offices to provide patients who have been identified as possessing low health literacy (Williams et al., 2002). Patients with low health literacy often do not fit a stereotype, and even patients with a fair amount of education may have low levels of health literacy specifically (Williams et al., 2002). Often times, physicians rely on preexisting written materials to reinforce or explain the information discussed during consultation, without being aware that this material is often at a much higher literacy level than the patient is able to understand (Safeer & Keenan, 2005). Techniques to help physicians deal with low health literacy during consultation have been researched over the years. For example, the use of visual aids to explain medical conditions—whether they be models or illustrations could be incredibly helpful for these patients (Houts et al., 2001). Some formal health literacy evaluation methods have been developed such as the Rapid Estimate of Adult Literacy in Medicine (REALM) 81 and the Test of Functional Health Literacy in Adults (TOFHLA) 82 in as little as 90 seconds, however these are rarely used and the literature does not suggest the use of these tools unless the physician is willing and able to adjust their communication methods to adapt to the lower health literacy of the patient (Davis et al., 1998). Williams et al. (2002) thus suggest that physicians be trained in how to address low-health literate populations. The American Medical Association, for example, has developed a tool kit with which physicians can train watching videos on different techniques to help them effectively communicate with patients who have low health literacy (ALA, 2000).

Access to Medical Information Online

Over the past decade, the rapid diffusion of internet technology has led to the public having an increasingly greater access to medical information online, and medical providers are no longer the sole provider of medical information or treatment options (Fox & Raine, 2002; Hesse, Nelson, Kreps, Croyle, Arora, Rimer & Vishwanath, 2005; Broom, 2005). According to some surveys, almost two thirds (63.7%) of adults used the internet to access health or medical information for themselves or for someone else (Hesse et. al, 2005). While there have been some policy research which advocates for the positive aspects of increased access to health information online—namely increased patient participation in their personal health management and more equitable patient-provider relationships—there is also evidence that it may impede health communication (Hardey, 2001; Hart, Hendwood & Wyatt, 2004). Some of the barriers created by the influx of online medical information include the eroding of patients faith in medical providers so that they are less likely to adhere to treatment recommendations, as well as the possibility of misinformation from direct-to-consumer commercial agencies (Huntington, 2002; Hesse et. al 2005).

A study from the UK surveying both patients and medical providers on the internet as a veritable source of health information revealed that it was more common for health providers to view internet use negatively, as it would encourage patients to challenge their medical authority (Hart et. al, 2004). Many physicians were worried that accessing the internet for medical information might lead to an inaccurate self-diagnosis that did not concur with their professional opinion, that patients might act on advice provided through unverified sources, or that it would increase patient anxiety by promoting hypochondria (Hart et. al, 2004). Clinicians have also reported feeling threatened by patients' information-seeking behavior and react negatively to advice provided in a consultation setting (Anderson et al., 2003; Henwood, Flis, Wyatt, Hart, & Smith, 2003). As one patient responds in a study by Hendwood et al. (2003):

> "I kind of researched it a little bit myself, looked it up, came up with suggestions and they don't like it or they'll say 'well, you might have heard that, you might have looked that up but that's not the case. The case is this'. And you can see them getting uptight, shoulders going up, arms crossing … I mean they might be right sometimes, I'm not saying they're wrong, they might well be right but they're not open. It's a closed door all the time. It's closed. It's black and white and you have got to be out of that [place] as quick as possible . . . there is no negotiation."

This increased level of patient empowerment can result in specialists' adopting various strategies to discourage this leveling in response to the transformation of the traditional paternalistic relationship between doctor and patient (Henwood et. al, 2003; Broom, 2005). However, this fear is unfounded as most online health information seekers do not see the internet as a replacement for their physicians (Umefjord et al., 2006).

As the internet becomes more and more accessible, it is unlikely that the number of online health information seekers will be reduced. Thus, it is important to discuss the vetting of authenticity and reliability of health information online so that should patients look to the internet for health information, they will access sources that provide accurate content (Heaton,

2011). Thus, it has been recommended by organizations such as the Centre for Health Information Quality in the UK that practitioners learn to work in combination with consumers to develop and find informational materials that are patient accessible and promote shared clinical decision-making (Henwood et al., 2003). Little more information has been found on the role that physicians may have to take to accommodate the presence of the internet in medical practice. However, intuitively it seems that there should be sensitization to patients who are internet health-information seekers, and would be useful for physicians to be educated on what credible internet sources are available and to help direct patients to these resources.

Nurses

Nurses comprise the largest component of hospital staff and often a significant proportion of primary care for patients in hospital and urgent care settings (Bell, 2000). Despite their prominent presence in primary care, the barriers and challenges to communication between nurses and patients -as well as the consequent health outcomes—have not been studied as extensively (Wanzer, Booth-Butterfield, & Gruber, 2004). The literature which does discuss barriers in communication between nurses and patients reflects similar hurdles as physicians. These include (but are not limited to) insufficient time, lack of solution to a patient's health concerns, and lack of knowledge regarding a patient's health concerns (Alexander, Casalino, Tseng, McFadden, & Meltzer, 2004). These barriers are also often patient driven as discomfort, insufficient time, fear of compromised quality of care, language barriers, and language have been cited by patients as perceived reasons for miscommunication (Alexander et al.; Rutledge, 2004).

There is additional evidence from Chant, Jenkinson, Randle & Russell (2002) that while nurses often innately possess the necessary skills for effective communication, they are often discouraged in the workplace from fostering interpersonal relationships with patients as a means of protecting nurses from emotionally difficult situations. This workplace culture and the traditional organization of nursing work, combined with the avoidance of emotional distress, act are barriers to establishing empathy and the implementation of effective communication skills (Reynolds, Scott, & Austin, 2000). This environment is ultimately detrimental to the care nurses can provide, as these interpersonal relationships are what form the distinction between nursing and caring (Milliard, Hallet, & Luker, 2006; Tuckett, 2005).

Chapter 3: Current State of Health Communication Training

This chapter will focus on the level of health communication in the EU as well as Canada, the US, and Australia and identify needs and obstacles that need to be addressed.

European Union

According to the mapping of formal and informal opportunities provided in health communication across the EU performed by the H-COM consortium, it is evident that the situation differes greatly between Member States. Although the search inherently carries certain limitations due to the search strategy (internet based) and also due to language barriers the consortium has obtained a fair perspective of the extent of health communication in Europe.

There are countries providing a plethora of training opportunities at undergraduate and postgraduate level (such as Germany and the UK) as well as continuing courses and workshops. In other countries training on patient-doctor-communication is not provided. In these countries, health professionals communicate with patients without being trained during and after study or vocational training. For example, for Lithuania, Latvia and Estonia no university level training opportunity was identified.

Training curricula in the majority of medical universities do not include obligatory communication-related modules for example in Greece and Poland. This could be a result of financial or staff shortages or a lack of understanding of the importance of health communication for the medical and nursing sciences. The UK and Germany provide more opportunities and are mandatory in Germany at undergraduate and postgraduate level in health communication training.

As far as continuing education, the H-COM partners identified 150 health communication training opportunities in the form of short courses, workshops and conferences in the EU. Most were one or two day study courses offered by professional organizations of the medical sciences specializing in vocational training for health professionals, as well as by universities. Short courses, workshops or seminars seem to be quite a popular way of providing training especially for postgraduate students, often offered either as stationary events or on-line courses. The majority of these courses were found in the UK, Ireland and Germany since health professionals are required to develop professional skills through the continuous personal development (CPD) scheme. Most were offered by third parties (private organizations specializing in education and training seminars) or the NHS and its affiliates. These courses aim to improve health professionals' communication skills, such as empathy, "layman's term language", talking about bad news or end of life prospects, dealing with difficult situations and active listening to promote better communication between their patients and their colleagues. However, these trainings are often insufficient. The review indicated that most of these trainings do not provide detailed technical skill and practical exercises (such as role-playing activities). Further they are often not mandatory, and do not build on a preexisting educational foundation in health communication.

In Europe there are limited examples of compulsory communication education; while many universities offer communication courses, they are often electives. The following are a few examples of universities from specific countries who have implemented compulsory communication courses after identifying a need in their curriculum for this specific skill set among their medical students. The following programs have been discussed in the available literature.

United Kingdom

Over the past twenty years, clinical communication skills (CCS) have been incorporated to form part of the general medical education curriculum for most medical schools in the United Kingdom, shifting from an under-recognized elective to a necessary skill (Peters & Livia, 2006). An ever-increasing large body of research work has been used to justify the inclusion of this material in medical school training. Aspegren and Lonberg-Madsen (2005) reported, for example, that experience alone was not enough to ensure adequate communication skills in medicine, and that even after ten or more years of clinical work, most physicians who had not take communication courses were unable to demonstrate basic communication skills. Conversely, a study from Willis, Jones & O'Neill (2003) noted that students who had received CCS training during their medical coursework self-reported a better level of understanding and diagnostic capability with their patients. Based off of studies such as these, CCS has become increasingly prioritized in UK medical schools (Brown, 2008).

CCS in UK medical schools is centered around the following types of communication in healthcare settings: (1) taking a patient history; (2) explaining (e.g. a procedure, test or risk, or giving information); (3) exploring (e.g. establishing what is going on for the patient); (4) discussing informed consent and options; (5) breaking news; (6) negotiating (e.g. a management or treatment plan); (7) passing on accurate information to colleagues (written or spoken), and (8) presenting a case history to colleague (Brown, 2008). Medical skills were traditionally taught through apprenticeship, though by the 1980s, it became clear that simple exposure and observation were techniques too passive to be implemented effectively (Brown, 2008). In response, the General Medical Council (GMC) of the UK, which regulates medical education throughout the country, produced a list of updated recommendations and in which CCS were included updated curricula (Maudley & Strivens, 2000). This document titled *Tomorrow's Doctors* included the following guidance, stating that medical graduates must be able to:

> (1) communicate with people with sensory impairment; (2) communicate effectively with individuals regardless of their social, cultural or ethnic background or disabilities; communicate with individuals who cannot speak English, including working with interpreters; (3) practice communicating in different ways, including spoken, written and electronic methods; (4) break bad news, deal with difficult and violent patients, and communicate with people with mental illness or physical disabilities, and (5) help vulnerable people (Rubin & Franchi-Christopher, 2002).

Tomorrow's Doctors prompted the institutionalization of communication as a critical aspect of primary health and community health education in the UK, as well as their assessment both inside and outside of the classroom (Jones, Higgs, deAngelis & Prideux, 2001). Expounding upon

the recommendations in *Tomorrow's Doctors,* the UK Council of Communication Teaching in Undergraduate Medical Education (UK Council) was formed as a community of practice with participation from most medical schools in the UK to establish a nationwide standardized curriculum for doctor-patient communication (Brown, 2008).

Belgium

The University of Ghent attempted to follow suit and begin to implement curriculum reform in its medical school in an attempt to focus on patient-centered care. Despite the knowledge of the benefits of health communication, communication training in Belgium is sorely lacking. Medical training in communication at the University of Ghent, for example, does not touch upon specific themes such as breaking bad news, genetic counseling, handling psychosocial problems or smoking cessation advice (Devegeule et al., 2005). In addition to failing to introduce these topics comprehensively during medical education, they are then not reinforced during their hospital residencies which due to their direct interaction with patients, presents itself as an ideal opportunity to learn and practice (Benbassat & Baumal, 2002) As a result, communication skills training needed improvement to manage its problems of continuity, insufficient hours of training, supervision and assessment (Devegeule et al., 2005) The University of Ghent went on to switch its curriculum to be more patient-centered, community oriented, targeting communication skills in each year of medical training and providing remedial training for students who performed poorly (Devegeule et al., 2005). Miller's framework is used as the basis for the didactic method for communication, which describes four tiers of interrelated learning stages: knowing, knowing how, showing and doing (Miller, 1990).

Sweden

Coordinated by the Department of Primary health care, consultation skills (CS) are taught as a course in Göteborg, Sweden during the clinical studies portion (5th term) of the medical curriculum (Wahlgyist et al., 2005). During this phase, the students learn basic consultation communication with an emphasis on the patient-centered approach, teaching future physicians how to encourage patients to convey symptoms, facilitate the exchange of ideas for the course of treatment, and addressing concerns (Wahlgyist et al., 2005). This approach emphasizes that the physician-patient relationship is asymmetrical, and therefore seeks to increase patient autonomy through negotiation and a shared understanding of the patient's medical concerns (Olesen, 2004). The course is nine weeks long, one of these weeks focusing exclusively on video-based consultation training using the Kagan Interpersonal Training method (Kagan & Kagan, 1995). These courses are often well received by students, who seem to take interest in interpersonal skills and empathy building (Wahlqvist, 2001). During the final year (10th term), three years after the CS course, students attend primary healthcare centers for two weeks during which they videotape their consultations under the supervision of a General Practitioner (Wahlqvist, 2001).

Health Communication training in the USA

The United States has been at the forefront of doctor-patient communication education in medical schools since health communication is among the subject areas physcians are examined for obtaining their medical licence (King & Hope, 2013; Traveline, Ruchinskas & D'Alonzo, 2005). Health communication has become a major topic of discussion in the past few years as a result of

major policy changes which have emphasized patient-centered medical care, particularly motivated by its inclusion in the Patient Protection and Affordable Care Act (Kilo & Wasson, 2010). As a means of progressing medicine to a patient-centered model, communication between patient and provider has come to the forefront as an important step to take (Levinson, Lesser & Epstein, 2010). Additionally, The Association of American Medical Colleges (AAMC) also declared that these skills should be improved through incorporation into medical school curricula (in order to improve this communication, there has been an increased focus on establishing educational programs incorporated into medical education (AAMC, 1999). As an example, in its June 2009 report to Congress the Medicare Payment Advisory Commission recommended that Medicare payments for medical education be linked to the development of such skills (MPAC, 2009). The National Cancer Institute (2007) provided a list of six fundamental purposes of doctor-patient communication to serve as a guideline for skill development programs in graduate medical education: "fostering healing relationships, exchanging information, responding to patients' emotions, managing uncertainty, making informed decisions, and enabling patient self-management."

Currently, in the United States, all medical schools are required to teach students basic communication skills (Kalet et. al, 2004). This has been a fairly recent development in medical education: in 1978, 35% of schools had a formal preclinical year curriculum in communication skills, and by 1993 this had increased to 65% of schools (Kalet et. al, 2004). The content of these courses often includes a combination of lectures as well as role-playing with "patient-actors" who incorporate feedback into the course module, in addition to the feedback provided by supervising residents (Levinson, Lesser & Epstein, 2010). Most of this communication skills education occurs during the first and second years of medical school. During these first and second years, medical students do not have direct interaction with patients; this direct contact occurs within the third and fourth years of medical education, when medical students are required to complete rotations. It is also during these latter two years that communication skills training fades out and is not reinforced, despite this being the two years that are most difficult cognitively and emotionally (Levinson, Lesser & Epstein, 2010). In more innovative medical programs, they are attempting to correct this gap through the incorporation of a number of different didactic techniques including active demonstration of interviewing techniques (Baerheim et al., 2007). However, despite this small incorporation of communication skills training in medical school, most medical students do not continue this training into residency and specialty training, with the exception of primary health (Levinson, Lesser & Epstein, 2010).

The increased focus of patient-centered care in the past decade has prompted institutions and medical societies to develop training programs catered specifically for practicing physicians. Notably, some of these programs in the US are offered through the Society of General Internal Medicine, the American Academy of Orthopaedic Surgeons, and the American Academy on Communication in Healthcare, or by large medical groups that have a dedicated cadre of physicians, such as Kaiser Permanente in Northern California (Tongue, Epps & Forese, 2005). The structures of these programs tend to be similar. They are usually conducted over a short period of time—between a half-day and three days—and include activities such as role play since it is deemed effective in increasing empathy and is also technologically low-cost (Levinson, Lesser &

Epstein, 2010). Topics discussed in these role play activities are scenario-driven, and focus on topics such as breaking bad news, disclosing medical errors, and discussing end-of-life issues. Conducted often times in small groups to maximize efficiency and the capacity to give productive feedback, these trainings have been particularly effective since their implementation (Levinson, Lesser & Epstein, 2010).

Two good examples of successful programs headed by a medical group to promote health communication training initiatives include the two insitutions Kaiser Permanente (California) and Park Nicollet (Minnesota). Both institutions have developed and tested extensive training programs to reinforce communication skills for medical providers, resulting ultimately in increased self-efficacy, self-reported communication capacity, and patient satisfaction (Stein, Frankel & Krupat, 2005). These efforts focus not only on communication skills trainings, but also foster leadership and intercollegiate learning practices using surveys, remediation classes for improvement, and the implementation of regular satisfaction surveys and evaluations (Stein, Frankel & Krupat, 2005). Medical groups are well equipped structurally to establish standards for communication in medical education settings as they expertly manage electronic communication, patient education providers, use ancillary professionals to assist provider trainings, and can regularly provide reporting on the development of health curricula (AMA, 2006).

Collaboration between US medical schools has also proved to be a successful initiative for the institutionalization of communication skills as a crucial aspect of medical education. Founded in 1999 by the Josiah Macy, Jr. Foundation, the Macy Initiative in Health Communication was formed as a three-year collaboration between medical schools—New York University School of Medicine, Case Western Reserve University School of Medicine, University of Massachusetts Medical School—to improve physician communication skills through the following:

> (1) defining a comprehensive set of communication competencies for medical students to master by graduation; (2) developing and establishing an integrated and comprehensive communication skills curriculum focusing on the clinical clerkship years; (3) design faculty development to support this curriculum; (4) evaluate the impact of the project; and (5) disseminate the findings. Each school developed and established its own curriculum and designed faculty development measures individually but worked collaboratively on competencies, evaluation, and dissemination (Kalet et. al, 2004).

The courses offered varied from university to university, but included situation and specialty-focused themes such as talking about sex and sexuality, dealing with angry patients, multiculturalism (Kalet et. al, 2004). The Macy Initiative was rigorousle evaluated at the participating schools, all of which were able to develop a cohesive, comprehensive health communication curriculum (Lurie, 2003). Analysis of the initiative by Kalet et al. (2004) stresses that success of the program lies in its focus on an integrative approach, inter-institutional collaboration, and institutional flexibility.

Chapter 4: Examples of Promising Practice

COMSKIL Model CST Sloan-Kettering Cancer Center

The Memorial Sloan-Kettering Cancer Center (MSKCC) in New York, USA, has developed the 'Comskil Model Communication Skills Training (CST)' program (Brown & Bylund, 2008). The theoretic background behind this program is based on the Goals, Plans and Action theory and Sociolinguistic theory. These models propose that communication is affected by specific goals people wish to attain from their exchange and the specific actions they take to achieve this. They also argue that if a more person-centered approach is utilized, by taking into account feelings and perspectives of others and reacting accordingly, it has the potential to promote better communication.

To curriculum of the COMSKIL Model is structured around this theoretic framework and employs a series of five distinct components of communication in sequence, all of which are necessary for an effective doctor-patient relationship: a) *Communication Goals* refers to the outcomes of communication during consultation (e.g. provide information to the patient about their health in a supportive manner). b) *Communication Strategies*, which refers to the methods required to achieve the goals set before (e.g. use of empathy during the consultation). c) *Communication Skills* are techniques the doctor can use, which can positively affect the previously mentioned strategies (e.g. summarizing information, respecting the patient's needs). d) *Process Tasks* are utilized along the above skills and act as buffers to the strategies, aiming to improve communication via specific patterns of speaking and non-verbal behaviors. e) *Cognitive Appraisals* constitute a process where the doctor pays attention to the verbal and non-verbal communication of the patient during the interview. This enables the doctor to examine worries or concerns the patient might have, which may not be explicitly stated during consultation. Patient cues (subtle prompts towards the doctor to provide clarification or support) and barriers (withholding information from the physician due to fear of a particular treatment's side effect) should be considered and explored carefully by the doctor, as they can potentially impede their relationship.

Teaching includes eight modules around common themes that come up during consultation (e.g. giving bad news), and are offered in 2-3 hour long small group sessions that include video presentations of good practice examples, exploration of the literature and role play. Participants are video recorded before and after the program and the faculty coders provide them with structured feedback.

The effectiveness of this program was examined in an evaluation study (Brown, Bylund, Eddington, Gueguen & Kissane, 2010). The research team focused on a particular module about 'Discussing Prognosis' and how it affected the 142 participants' communication skills regarding this matter. The overwhelming majority of learners reported feeling satisfied by the level of training received and considered themselves more confident in their use of communication skills when discussing prognosis with their patients.

Oncotalk – Communication Skills for Medical Oncology Fellows

'Oncotalk' is a CST program funded by the National Cancer Institute in the US. It is specifically targeted at medical oncology fellows who wish to improve their communication skills with cancer patients (Back, Arnold, Tulsky, Baile & Fryer-Edwards, 2003). The theory behind the model of this program is that knowledge, experience and attitudes towards health care can promote the doctor-patient relationship, and these can be improved by practicing communication skills with personalized feedback.

The program takes the form of a 4-day retreat, with formal teaching sessions offered to participants throughout the duration. The curriculum includes 25-minute long, group presentations which focus on specific communication tasks and learning objectives based on empirical evidence (e.g. Transition to palliative care, Family conference). The faculty engages in role-play with the participants and discusses the different themes presented and ways to achieve each unique goal. After each presentation, 2.5 hour-long, small group communication skills training sessions take place around the theme that was previously discussed. Participants engage with trained patient-actors in a simulated interview setting, with personalized structured feedback provided by the faculty and the patient-actors immediately after each session. Afterwards, learners engage in role play sessions where they can also take the role of the patient in similar interview scenarios to explore their own experience from the patient's perspective, while receiving feedback by the trainers, as well as their peers. The final part of the training includes reflective exercises, where participants are asked to reflect on their experience from the sessions to help them become aware of emotions, beliefs and thoughts that can affect the doctor-patient relationship which arose during the role-play. After the training program, participants are prompted to select two of the explored skills and use them in their practice for a month, while receiving feedback via telephone from the trainers.

A study (Back et al., 2007) evaluated the efficacy of this program, by analyzing changes in the communication skills of participants who took part in this training. With the help of trained standardized patients, different than the patient-actors used during role-plays, participants' communication skills in giving bad news and discussing transition to palliative care were evaluated before and after the sessions. Of the 115 participants, up to 78% of them demonstrated utilization of newly learned skills on delivering bad news and up to 86% on discussing transition to palliative care.

Intensive Communication Skills – Institute for Healthcare Communication

The Institute for Healthcare Communication (U.S) has developed the 'Intensive Communication Skills' training program for practicing physicians who wish to improve their communication with their patients in the clinical setting. The program is based on best practice examples from theories of communication, the ethics surrounding doctor-patient interactions, the improvement of skills and competencies and the ways personal history can affect this relationship. Participants will be able to experience the consultation process from the patients' perspective, utilize the necessary skills to promote their relationship and recognize how their own personal experiences can affect their communication with the patients.

This Intensive Communication Skills program is divided into three distinct parts, which participants must complete in order to improve their communication. A) Course Readiness, refers to a period of one month prior to the actual training workshop. Participants receive published articles about doctor-patient relationship which are encouraged to read, as well as seek relevant input about their own communication skills (e.g. via patient surveys). B) Skills Workshop is the 2-day residential program participants undertake. Small groups of three to four learners receive training from faculty members, who are experts in the fields of medicine and psychology. The curriculum consists of communication skills practice with standardized patients, guidance from the tutors, video presentation of good practice examples during consultation and the way that doctor-patient relationships can be shaped by theories, values and personal history. C) Coaching and Feedback, refers to a period of 6-12 months after the end of the training where participants can be allocated a clinician coach from the Institute, or are free to find one from other resources. These coaches work alongside the participant and help them maintain and further develop the communication skills learned by providing feedback, support and guidance.

The efficacy of the Institute's training workshops has been examined by studies on empathic communication (Bonvicini et al., 2009) and doctor-patient satisfaction (Haskard et al., 2008), with positive results.

Four Habits Model – Kaiser Permanente

Kaiser Permanente is one of the largest health maintenance organizations in the US, with a great number of practicing physicians providing health services to millions of patients. This organization has recognized the importance of good doctor-patient communication and the ways it can affect their relationship. As a result, it has implemented a variety of communication skills training programs for its staff members, in order to promote the consultation and interactions with their patients. From 1990 to 1995, the Thriving in a Busy Practice program was offered, which provided training to physicians. In this workshop, doctors were asked to reflect on patients' experiences and feelings about their health condition, and afterwards the tutors would present useful communication skills to manage difficult situations with uncooperative patient-actors.

Following revisions of the program in 1996, the 'Four Habits Model' was introduced and has been an integral component of several communication skills training programs offered by Kaiser Permanente up until today (Stein, Frankel & Krupat, 2005). 'Habits' refer to specific ways of thinking and acting during consultations, which have the potential to affect the doctor-patient relationship. These are divided in four parts: a) '*Invest in the beginning*'. This Habit is utilized during medical interviews and early consultations. It teaches communication skills that enable the doctor to establish rapport with the patients and explore their concerns regarding their health. Examples include politely introducing one's self to the patient, considering their cultural background and acting accordingly (e.g. eye contact) and repeating information to the patient to ensure they have understood. b) '*Elicit the Patient's Perspective*'. In this Habit, doctors learn how to prompt patients to share their ideas and worries about their health concern and how has that affected their daily life. During this part, they also ask the patients to share their thoughts on which kind of treatment plan they would wish to follow. c) '*Demonstrate Empathy*'. This Habit

aims to promote an empathetic approach towards the patients. Doctors receive training on how to engage with patients' emotions on a personal level and show understanding and acceptance for their concerns. d) '*Invest in the End*'. The final Habit revolves around the matter of sharing specific medical information with the patient about their condition and treatment plan, as well as teaching ways to involve the patient in the decision making process.

The study by Runkle, Wu, Wang, Gordon and Frankel (2008) explored the efficacy of the 'End of Life' workshop offered by Kaiser Permanente, which is based on the theoretical background of the Four Habits model. This training program teaches clinicians the necessary skills to interact with patients and their families about the transition to palliative care and how this affects their quality of life. Participants who attended the workshop completed a survey three months later, where they reported being more knowledgeable about the specifics of palliative care and feeling more confident in their skills to talk about end of life prospects with their patients in the future.

Clinician-Patient Communication Program - Physician Assessment and Clinical Education (PACE) Program, University of California, San Diego

The University of California, San Diego (UCSD), has developed the Physician Assessment and Clinical Education (PACE) Program for clinician enhancement (Norcross, Henzel, Freeman, Milner-Mares & Hawkins, 2009). The PACE program has been developed, and has been in effect since 1996, as a way to assess the performance and professional competency of practicing clinicians in those cases where deficiencies have been identified and referred, and provide training and education in order to rectify them. Some of the main outcomes of the training program are to provide clinicians with a greater understanding of the ways effective communication skills can lead to desired clinical outcomes, as well as allow them to recognize the importance of this communication as an essential aspect of health care.

The PACE program is divided into two parts: a) 'Phase I' is a two-day examination period, where the physicians pass through a series of extensive tests evaluating their competency levels on clinical and practical expertise with simulated patients, interpersonal communication, computer literacy, history taking and medical interviewing skills. b) 'Phase II' is a five-day formative and summative assessment of the physician's clinical skills. Based on the evaluation following 'Phase I', the physicians receive training at the residency, or fellowship program of their specific medical specialty at the UCSD Medical Center. A multidisciplinary group of faculty members of the School of Medicine provides training to participants, helping them acquire new knowledge, techniques and skills to improve on their practice, with a particular focus on fostering a lifelong learning experience.

Between 2002 and 2005, 298 physicians took part in the PACE program, either through referrals or on their own, to improve their competency skills. Out of these participants, only 17 (less than 6%) did not achieve the minimum quality standards set by the faculty of the UCSD, while the remaining majority reported their satisfaction with their training program.

The Basel Consensus Statement – Basel, Switzerland

The medical school curriculum in German speaking countries has in the past decade evolved to recognize the importance of including communication as a core competency, yet until recently there had not been defined outcomes and educational objectives (Keissling et. al, 2010). Following the precedent of communication competency-based documents such as the Kalamazoo Consensus Statement, an interdisciplinary group of experts from different medical schools in Germany, Austria, and Switzerland developed the guideline called ‘‘Basel Consensus Statement’’ aiming to support planning, improving, and evaluating educational programs in the field of communication skills and social competencies (Keissling et. al, 2010). The initial meeting was held in 2006 in Basel, Switzerland featuring 30 persons including professors, students from a variety of medical schools and specialties with the intention to describe a minimal standard of competencies every graduate should have achieved at the end of their studies. The Delpi Method was used to determine expert opinions anonymously until convergence. This was followed with a two-step survey which involved over 100 academics from over 30 institutions.

The meeting resulted in a consensus statement with 19 topics and 131 educational objectives grouped into general and specific competencies. In contrast to the Kalamazoo Consensus—which focuses specifically on the medical encounter between physician and patient—the Basel Consensus has a much broader range of objectives which includes topics such as teamwork, social responsibility, and personal and professional development have been included as well (Keissling et. al, 2010). The most highly ranked educational objectives with 100% level of importance (meaning all experts had rated the objectives as most important, very important or important) were: 1) encountering the patient with respect, 2) identifies own strengths, weaknesses and limitations, 3) adapts oneself to the patient’s understanding and language. (Keissling et al., 2010). As a result, the most important objectives centered on attitudes and values as opposed to those based on factual knowledge. Keissling (2010) and the other producers of the report suggest the results of the consensus indicate a greater need to ultimately reform medical school curricula to improve opportunity and assessment in these noncognitive fields.

The Basel Consensus was later used as the basis of a latter consensus, the Health Professions Core Communication Curriculum (HPCCC) in 2008. The European Association for Communication in Health Care (EACH) established the subcommittee ‘‘tEACH’’ to support the development of communication teaching throughout Europe, ultimatel establising a work-group with 46 experts from 18 European countries and represented specialties included medicine, midwifery, nursing, pharmacy, psychology, dentistry and physiotherapy. Experts were presented with 61 core communication curriculum objectives, all of which had high acceptance rates (Bachmann et. al, 2013). Quantitative analysis revealed that on average all communication objectives had a high relevance for education in all health care professions with a range from 84 to 100% with 11 objectives had an acceptance of 100%, meaning all experts had rated the objectives as most important, very important or important (Bachmann et al., 2013).

Much like the Basel Consensus, the HPCCC does not provide specific tools for application of these core competencies, but instead delivers a framework to support ongoing development as

well as greater legitimacy to the incorporation of communication courses into medical curricula across European States.

Chapter 5: Country Reports

Participating partners were asked to perform literature reviews discussing barriers, facilitators, and suggestions for training within their respective countries. Each country was responsible for identifying and analyzing literature relevant to their countries' stances on the current state and development of physician-patient communication. This is with the hope of identifying similar themes throughout the participating EU members, synthesizing them, and developing solutions addressing recurrent themes in health communication.

Greece

Background information on Health Communication in Greece

In Greece, the matter of effective health communication as a means to improve the health professional's relationship with the patients, has been examined in a more thorough way only relatively recently, following the breakthrough studies produced during the 1990's on the subject. Researchers in Greece have been adamant on the importance of good doctor-patient communication in the provision of health care. They agree with the international literature suggesting that the focus of health care provision has been gradually shifting from the old, medical model of treatment (how to cure the acute effects of an illness), to a more modern model which places the patient at the center of attention (their experience of the disease, treatment of chronic conditions, emphasis on prevention and promotion of health) (Lionis et al., 2015; Panagopoulou & Benos, 2004; Tsimtsiou, 2006; Veniou & Tentolouris, 2013).

A number of studies have been conducted in Greece to examine and assess the matter of health communication, mostly by focusing on the matter of doctor-patient relationship and patient satisfaction with their health care.

A study (Polysos, Bartsokas, Pierrakos, Asimakopoulou & Yfantopoulos, 2005) presented the findings from a comparative survey of patient satisfaction between two hospitals in Athens, a non-profit specialized hospital and a general public one. Patients were asked to rate their satisfaction with various aspects of their experience at the hospital, such as their quality of stay, admission and waiting times and their impressions with the health staff. Patients rated the level and quality of information about their treatment plan, prognosis of their disease, guidelines to follow after their discharge regarding their health, kindness and understanding of the medical staff. In the same way, they rated their satisfaction with the nursing staff and the health care services they provided, their kindness, understanding and willingness to help. Overall, patients reported feeling more satisfied with their care from the non-profit hospital (91.1% reported cumulatively 'Good' and 'Excellent' impressions) than the general public one (75.2% respectively). Similarly, they evaluated the medical and nursing staff more positively in the first hospital (both at 92.7%) than the second (71.3% and 84.4% respectively). In both hospitals, patients reported feeling more satisfied with how they were 'treated' by the medical and nursing staff (administering of medication, kindness and understanding), than how they were 'informed'

(provision of information about their condition and guidelines to follow after discharge). They argued that the staff did not provide them, or their relatives, with enough and clearly defined information on how to best manage their health condition (medication schedule, behaviors to follow or avoid) after their discharge.

The researchers mention that differences in satisfaction levels between the two hospitals could be attributed to some specific factors. The general public hospital was newly founded at the time and was going through administrative changes, as well as experiencing cases of understaffing. They argue this could have potentially affected patient satisfaction levels, as the medical staff may have been unable to properly cater for each patient to the fullest extent. As it was mentioned earlier in the review, time constraints and work pressure can act as barriers and have a negative impact on the communication between doctor and patient. The researchers conclude that changes such as these should be planned and implemented in certain ways, so as to prevent any unnecessary burden on patient satisfaction. They also argue that medical staff should follow a continuous personal development and educational regimen, in order to respond faster and more efficiently to their patients' needs, as well as be able to provide better information regarding their health (Polysos et al., 2005).

Similar findings were reported in another study (Papagiannopoulou, Pierrakos, Sarris & Yfantopoulos, 2008), which measured parents' satisfaction levels with the health care their children received in a pediatric hospital in Athens. Although parents reported feeling generally satisfied with the services provided by the medical staff, they argued that certain areas could be improved. Specifically, they reported feeling more satisfied by the way the doctors treated their child's disease (information on medication uptake, kindness and understanding) than how they informed them about the specifics (clarity of information about the nature of the disease and guidelines for behavioral changes after discharge). On average, parents also reported feeling generally satisfied with the nursing staff services, but not as high as the medical staff. The researchers reported that nurses tend to spend more time with patients and in this case with concerned parents as well. This can often cause frictions between them and hinder their communication, which can potentially have a negative effect on patient, and carer, satisfaction levels (Papagiannopoulou et al., 2008).

Another study (Minaki, Samoli & Theodorou, 2013) examined the issue of patient complaints from their experiences with hospital care. Data was collected from one specialized public hospital and two general university hospitals in Athens. In the sample of 105 patients, or their relatives, complaints targeted the administrative (43.3%), medical (40.7%) and nursing staff (16%). In all cases, and most prominently for the medical staff, complaints regarded the matter of poor or improper communication between the hospital staff and patients. Other complaints addressed issues of long waiting times, lack of biomedical equipment, professional conduct, malpractice claims and the quality of nursing care. The nursing staff received the majority of complaints from the pathology (inpatient) ward, while the administrative and medical staff from the outpatient clinic and emergencies departments.

The researchers argue that, the prolonged stay of a great number of inpatients may cause frictions with the nurses who, in the cases of understaffing, may experience burnout and are

unable to tend to their every need. They also mention that Greek public health services are often afflicted by a lack of proper administrative organizing and slow bureaucratic processes, which tend to impede effective communication between health care staff and patients. This, in turn, has a detrimental effect on their satisfaction levels from their health care and often leads to complaints (Minaki et al., 2013).

Similarly, Kalogeropoulou (2011) conducted a patient satisfaction survey in six public general hospitals. The findings showed that 67% of 300 patients were overall not satisfied with their care. Regarding their relationship with the health care staff, they reported dissatisfaction with issues of providing their written consent, not receiving clear information and briefing about their health concern or treatment options and the specific medical processes regarding their therapeutic plan. They argued that both the medical and nursing staff should improve on these figures in order to treat them in a more acceptable way.

Barriers and needs to effective communication

Taking all of the above in consideration, the matter of good provider-patient communication has many different layers and can be impeded in a variety of ways. As it was mentioned earlier, many public hospitals in Greece frequently face cases of nurse understaffing. As a result, nurses often have to provide care to a disproportionately large number of patients, with cases of fatigue, burnout and job dissatisfaction being reported often. Data from the OECD (2015) shows that, in Greece there are 3.6 nurses per 1.000 of the population, one of the lowest percentages in respect with the number of inhabitants (OECD-34 average 9.1). The ratio of nurses to doctors shows that Greece is at the bottom of the list, with only 0.6 nurses available per doctor, whereas the OECD-34 ratio average is closer to 2.8 nurses. Under this light, it shouldn't come as a surprise that their health communication capabilities with their patients can, at times, be negatively impacted. There is a direct link between this reported lack of staffing and the subject of busy schedules and lack of time, where health professionals often face difficulties in catering for a great number of patients.

Another barrier to effective communication lies within the organizational structure of the Greek Health System. In many cases, patients are placed within an antiquated health system of the public sector, which has been severely affected by the ongoing economic recession (Karaiskou, Malliarou & Sarafis, 2013). While various modernizing efforts have been proposed or are in stages of implementation, the upgrading process is being constantly hindered by frequent budget cuts and fund draining from the health system's treasury reserves. This has had a direct effect on health providers' morale (salary cuts, insecurity, job dissatisfaction), which in turn has the potential to negatively affect their communication with the patients.

Additionally, health literacy plays another major role on health communication between health professionals and patients. Findings from the European Health Literacy Project 2009-2012 (HLS-EU Consortium, 2012) report that about 45% of the population in Greece show 'inadequate' or 'problematic' levels of health literacy. This means that about one in two Greeks fail to properly understand details regarding their health, such as preventive actions, the ability to seek, acquire and process medical information concerning their health or the ability to make informed

decisions on medical issues. As a result, health professionals often find themselves in the position to treat patients who may not fully understand the nature of their health issues, treatment plans or medication schedule. In these cases, there is a language barrier which impairs good communication which puts the pressure on health providers to adapt to each patient's specific level of understanding.

These above mentioned systematic deficiencies of the Greek NHS, in combination with the reduced health literacy levels of the population, often lead people to seek care directly from higher levels of healthcare institutions, such as hospitals and their outpatient services. This matter exerts further pressure on the already busy schedules of health professionals, who have to provide their services to an unnecessarily high number of patients. A major issue in Greece is the lack of the concept of the General Practitioner, who would normally be the first person a patient contacts in the case of a health concern. They would act as the interconnecting factor between the primary and higher levels of healthcare, by clearly informing patients about their condition and what specific actions they need to take in order to seek further health services. Many of the hospitalizations cases in Greece could be avoided by proper communication between health professionals and patients, as well as better communication between the different parts of the health care system (Tsimtsiou, Kiparoglou, Asimakopoulos, Efthymiadou & Dantsi, 2012).

Training in health communication

When it comes to the matter of health communication training for health professionals in Greece, the literature suggests that such opportunities are scarce (Liangas & Lionis, 2004; Λιονής et al., 2015; Veniou & Tentolouris, 2013; Μποστανίτης & Τσαλίδου, 2010). Researchers from the fields of medicine, sociology and public health, report that such training, aiming to enhance the communication in the provider-patient relationship, is only offered during the academic studies of medical or nursing students. They argue, however, that even in those cases, such training is offered in the form of taught modules, occasionally elective ones, lasting no more than a few semesters early in the six years of medical school training. In previous decades, before the importance of good health communication became the subject of extensive research, it was erroneously believed in Greece that good communication skills were part of a person's personality traits and moral values and that it was not possible to acquire or improve on them via training. This has been slowly changing with the introduction of such classes aiming to promote the good working relationship between medical and nursing students with their future patients.

However, they further remark that, such communication skills are not properly, or accurately, assessed during final examinations by following a structured or objectively measureable way of evaluation. The same studies reference information from the scientific literature on the importance of communication skills training on the doctor-patient relationship and potential positive health outcomes, in the same light that has been presented earlier in the review. They also mention that health professionals' communication skills tend to deteriorate over time, and because of residency constraints and busy schedules, health professionals are not often able to participate in training programs to improve their health communication skills. The researchers

also talk about the lack of vocational training opportunities on this field, and as a concluding remark, urge for the need to increase the number of such communication training programs in Greece with the aim to promote the doctor-patient relationship.

Cyprus

Background introduction to health communication related aspects in Cyprus

Literature and statistics "The health public system of Cyprus" has a large network of providers throughout the country. This network operates alongside that of the private sector, although data and documentation regarding the private sector is sparse. In Cyprus, practicing physicians are 3,027, a number that correspond to 3.5 physicians per 1000 population and practicing nurses are 4,260 that corresponds to 4.9 nurses per 1000 population (CyprusProfile.com, February 2016). The link between secondary care and the social care system is informal, the latter being mostly the responsibility of the Ministry of Labour and Social Security. The fragmentation of the health system, with little continuity of care and poor communication between doctors and other health care providers within and between the private and public sectors, is a major weakness. It leads to inefficiencies in both sectors, duplications of service and underutilization in the private sector.

Evaluating hospitalization in public hospitals, the vast majority of patients reported being very satisfied with health professionals in various aspects including communication, respect, politeness and visit duration [See Table 1]. Another study that was conducted in Cyprus measured the satisfaction of patients by services provided by the outpatient departments in four public hospitals (Gabriel, Theodorou & Middleton, 2012). It was found that on a 5-level Likert scale 1; 'complete agreement' and 5; 'complete disagreement', there was a high score expressed for communication and quality of instructions, with a mean value that ranges from 3,82 – 4,01. The sample comprised of 761 patients in the outpatient departments of the hospitals, obtained by systematic sampling. This high level of satisfaction was attributed to patients possibly over-reporting satisfaction levels. In a study conducted to examine patient satisfaction in public hospitals, patient satisfaction with nursing care was found to be unexpectedly high. This can partly be attributed to patients' lack of specialized knowledge on the matter, or due to patients' fear due to their dependence on hospital personnel (Merkouris Andreadou Athini Hatzimbalasi Rovithis, & Papastavrou, 2013). This notion has been supported by Obserst (1984) who explains that the average patient does not possess the experience or the necessary knowledge to assess the technical aspect of medical and nursing interventions. For example, surgical patients tend to be more satisfied with information given to them due to the nature of the disease and the relationship between the patient and the doctor. Patients who are admitted for a scheduled operation had more time to learn more about their problem or they had been informed about it in advance and prepared themselves.

In the Merkouri et al. (2013) study it was also found that patients in hospitals of smaller cities were more satisfied than those in large urban areas. This is in alignment with previous evidence in the USA and Canada with rural patients reporting better care than urban patients (Wallace, DeVoe, Bennet, et al. 2008). One potential explanation could be that patients in large

communities may have different expectations because they have a choice. Another possibility is that people in small communities may develop close social connections with the hospital personnel, and therefore show greater satisfaction with the services they offer.

Unfortunately, there is no any other published literature from Cyprus concerning the effect of communication on different situations in health care or on attitudes and decision making concerning health issues. Therefore, there is a lack of quantitative and qualitative research on health communication effects in Cyprus.

Triggers and barriers of patient-doctor communication

According to both patients and doctors for there to be good patient-doctor communication there must be mutual trust and respect between the two parties. Patient-doctor communication can be facilitated by the physicians offering the right kind of psychological support. Patients explained that the limited availability of doctors, and along with that, the 5 shortage of time results in poor quality of doctor support in the public health settings. Therefore dedicating time to patients was something that facilitated and enhanced communication. On the other hand, health educators' perspective is that to trigger patient-doctor communication there needs to be effort on behalf of the physicians, i.e. doctor preparation, introduction, sign-posting, building positive rapport and engaging in active listening. These techniques and skills are what facilitate good patient-doctor communication.

Physicians working in the public sector have reported that the main barrier for patient-doctor communication is the lack of an organized and integrated system of patient information. This results in them only having access to information that is provided by the patient and therefore not knowing the medical history of the patient. This perspective was shared by patients too. Moreover, there was also emphasis placed on the lack of a penalization system resulting in doctors getting away with bad practice.

Needs, obstacles and perceptions of patients and physicians regarding health communication

Patients reported that, in general, doctors do not provide patients with the right type and quality of communication. They report that health communication is the key factor in information exchange (i.e. that the doctor must accurately and adequately inform the patient of their diagnosis, treatment plan, etc.). An obstacle to health communication is that doctors fail to properly explain the severity and nature of patients' illness. Patients' needs for more effective health communication are as follows:

a. Evidence-based explanations by the doctor (i.e. using evidence-based information to explain to patients their illness)

b. Simplified language that is not heavy with medical jargon

c. Mutual trust and understanding on both parts

According to patients the use of medical or foreign language stands as a major obstacle to health communication. It was explained that patients who do not understand English have major

communication issues due to the lack of translators available in both private and public health settings. This was also the perspective of physicians who explained the difficulties they face as a result of patients' low health literacy skills.

Moreover, the lack of a unitary medical record-taking system means that physicians are unable to access a patient's medical history. This results in difficult understanding the history of the patient as they depend on the written report which may be lacking key information.

Also, doctors' limited availability and time resulted in patients not being able to receive information that they needed. Patients' perceptions are that doctors do not provide patients with the right amount of interest and care, also underestimating patients' capacity to understand. Physicians share this belief and explain that the Cypriot health system is severely lacking in its infrastructure system. In other words, the lack of time, high amount of bureaucracy and poor organization stands as a big obstacle regarding health communication.

Patients perceive communication to be the key factor in information exchange, yet acknowledge that this is severely under-developed in Cyprus. Once again, physicians in the public health system are generally restricted for time and do not devote enough attention to patients' needs. Physicians working in public health hospitals report that there is an overwhelming number of patient visits per day, resulting in them not having enough time to attend to their needs. It is important to note that although there are major communication problems in the public health sector, patients report that some doctors in the private sector have the capacity to communicate more effectively due to higher time availability. Still, they explain that even in the private sector physicians will not properly communicate with patients given that they underestimate patients' capacity to understand.

It is therefore clear that patients and physicians share similar ideas regarding the needs, obstacles and overall perceptions regarding health communication.

Training and educational opportunities for health communication among health professionals

Research conducted via the Ministry of Health and Private Medical Institutional bodies has shown there to be no existence of health communication training programmes in Cyprus.

Regarding the general trainings that are given to practicing physicians in Cyprus, the main responsible authorities are the Medical and Public Health Services (MPHS) Department of the Ministry of Health (MoH), the Cyprus Medical Association and the Private Clinics. Specifically, the MPHS provide seminars and trainings to medical doctors under training, but there are not included subjects related to Health Communication. In Cyprus there is no requirement for doctors to receive continued training but the opposite is the case for nurses who are required by their association to fulfill specific credits on an annual basis.

The Cyprus Medical Association didn't provide any training related to Health Communication since 2014 that there is available data (http://www.cyma.org.cy/). There is no available information about trainings conducted by Private Clinics. In addition, Department of Intensive Care in Nicosia General Hospital offers education and training to health professionals, patients

and their families but topics about Health Communication are not included in their objectives 7 as primarily psychologists are responsible for the communications

(https://www.intensivecare.com.cy). Physicians working in the General Hospital reported that they were not aware of such programmes, neither were they ever trained on health communication between patients and doctors during their careers in Cyprus. However, there are academic programmes offered in a Cypriot private university on 'Clinical Communication'.

Best practices for improving health communication among MDs

Educators in the health sector stress the importance of a multi-angle, culture-centred training. In other words, to improve health communication there need to be training programmes that start either from the government implementing new medicinal training policies, or from younger doctors transferring knowledge to older doctors. Furthermore, it is necessary that health communication training programmes form part of the doctoral credit system. According to health educators the absence of a lifelong learning medical credit system inhibits skill development even more as well as doctors' health communication skills. To create progress in this area, physicians need to be intensively trained on patients' psychology, managing time and how to adapt to different patients. The content and structure of such training would have to adhere to clinical communication models such as Kalamazoo Consensus Statement', UK Communication Curriculum Wheel, Calgary-Cambridge model and engage in various learning techniques (e.g. role play, simulated training and online learning).

According to health educators it is recommended that to improve health communication the following must be put in place:

- A penalization system centred on communication that penalizes physicians'' bad practice
- Higher transferability and acceptance of new knowledge among the physicians
- Creation of training opportunities on health communication that will be obligatory as part of the of the doctoral credit system

On a societal level it would be necessary to increase health literacy skills as this is one of the main reasons that patients feel they do not have a 'voice' in medical appointments. This opinion was shared by physicians and health educators too. Increased knowledge and higher awareness regarding health aspects, as well as understanding of their rights would serve to improve health communication with physicians. In fact, it has been suggested that in Cyprus nurses should be made more sensitive and aware of the importance of patients' information and autonomy, as well as of their rights in general (Merkouris, Andreadou, Athini, Hatzimbalasi, Rovithis & Papastavrou, 2013). This is in compliance with the World Health Organisation (WHO) which defines health literacy as "the cognitive and social skills which determine the motivation 8 and ability of individuals to gain access to understand and use information in ways which promote and maintain good health" (WHO, 1998). There are three levels to health literacy:

1. Functional health literacy: it involves having knowledge about the health condition and services.

2. Interactive health literacy: the individual is able to access services, negotiate treatments and interact with the health system.

3. Critical health literacy: the individual is able to mobilise resources for collective action.

Despite important gaps in the area of health communication in Cyprus, there have been efforts towards a unitary patient record system as reported by the Ministry of Health (2014). Specifically, reference was made to the promotion of "online collaboration between patients and health service provider, the exchange of data between different health organizations and communications between patients or health providers." The report explains that the main reason for heading in this direction is due to the EU objectives to create an electronic heath record system.

Therefore, e-Health activities n Cyprus are at early stages. The Ministry of Health has started taking advantage of e- health standardization processes (to create infrastructure for electronic health records) at 2 large hospitals (Nicosia General Hospital and Famagusta General Hospital), as well as, the effective management of electronic materials and electronic prescription. Additionally, the Ministry of Health began to implement various projects that contribute to a better approach to cross-border healthcare. Some of the most important projects are as follows:

a) The development of an Integrated Health Information System, which consists of 13 subsystems that have to do with the running procedures of hospitals, such as electronic patient record, patient billing, managing e-prescription, laboratory tests, etc. The Integrated Health Information System is supposed to cover the key elements of hospital activities, to control both the quality provided to patients as well as to control the costs related to care provided. The Integrated Health Information System operates in Nicosia General Hospital and Famagusta General Hospital and some of the Health Centres in the two districts.

b) Drugs Information management system. This system operates in all hospitals, pharmaceutical stores and many health centres.

The future goals of Ministry of Health are:

a) The creation of Regional Health Networks (RHN) to exchange information in real time between all hospitals, Health Centers, regional clinics and private doctors. The RHN will enable healthcare providers to have access to the right information, any time they want for better and higher quality medical care.

b) Regional Health Networks will offer direct access to:

    i. the prescription and the results of laboratory tests

    ii. transfer of information to and for each patient

    iii. appointments

    iv. single medical record

v. telemedicine, telecare and telemonitoring and ambient assisted living (AAL)

vi. clinical protocols and treatment guidelines patients

vii. administrative and management systems Based on the aforementioned it seems that the Cyprus Ministry of Health are at the early stages of implementing a system that could potentially improve the health communication aspects between doctors and patients.

Germany

Introduction to health communication related aspects in Germany

In 2015, about 174 391 physicians and further 1 018 461 persons (hospital staff, e.g. nurses) worked in German hospitals (Statistisches Bundesamt, 2015). Related to the number of physicians, 19 183 461 hospital-patients seems really high (Statistisches Bundesamt, 2015). Given this large proportion of patients to physicians, ensuring an unobstructed process in the medical care of every patient is one of the most important duties within a hospital and its educational system.

However, most of the time medical practice focuses on giving correct diagnoses, appropriate medication and on diverse planning requirements, such as surgery schedules. Improving the style of communication between patient and physician seems to be trivial. Still, communication is the key to making the right diagnosis, providing appropriate medical treatment and ensuring optimal planning of surgeries, not only in hospitals, but also in private practice. It is therefore essential to pay increased attention on the meaning of communication, and to improve our empirical knowledge on processes of communication (Richter-Kuhlmann, 2015).

According to Geisler (2004), communication between physician and patient should be an instrument for the quality of their relationship. Only in conversation with their physician, patients get to know the qualities of the doctor, such as his knowledge and medical abilities. In addition, the well-being of patients increases when doctors communicate their diagnosis in an appropriate way (Langewitz, 2002). The ability to properly communicate seems to be important for the physician too, regarding his own health and feelings: he learns more about the patient's problems, it is easier to find diagnoses, thus it leads to reduced stress and an increase in satisfaction with the job (Geisler, 2004). Physicians should know different styles of communication for a diversity of medical contexts and situations, including delivering bad news such as a cancer diagnosis. Conversations with patients should be structured and at the same time empathic; all necessary information should be given, but the conversation mustn't be overloaded with medical terms (Langewitz, 2002).

Empathy is one of the most important parts of good communication in clinical contexts. Communication should be empathic not only with adult patients, but also with children and their relatives (Nikendei et al, 2011). When talking to parents about their children's illness, doctors should be gentle but objective –a recommendation that seems difficult to understand for some

paediatricians and physicians in general practice. But education can have a positive impact on this challenge: Paediatricians that participated in a communication-training showed better results in building a good relationship with parents, compared with those who had not received any training (Nikendei et al., 2009).

Communication also plays a role in other special areas, such as gynaecology. A study by Wegwarth and Gigerenzer (2011) indicates that gynaecologists often give too little information, for example describing a mammography screening as a very safe method without explaining its inherent risks, or conversely, describing its risks by using too many difficult to comprehend medical terms. These studies highlight the need of teaching physicians some tools for effective communication, including the explanation of risks in simple and understandable terms for every patient.

In sum, improving our knowledge and skills on doctor-patient communication is a pressing need. Output 3 of the H-Com project aims to thoroughly describe and analyse the situation concerning health communication among healthcare professionals in a comprehensive state-of-the-art report. This literature review shall serve as a framework for identifying health communication needs and training methodologies specifically relevant to the German context, but potentially of comparative value among other implementation sites of the project.

Methods

We performed an extensive systematic literature review including published research and grey literature, following standard procedures of scientific research from 2000-2016. We searched online on PuBMED and ISI Web of Knowledge from 2016/06 till 2016/08 for literature dealing with: Health communication, health communication and physicians, doctor-patient relationship, health communication training needs, barriers to health communication, patient-centered communication, communication curriculum, communication training, and communication skills. We also searched for the German words: Arzt-Patient-Kommunikation, Kommunikation, Arzt-Patient-Interaktion, Gesprächsführung, Arzt-Patienten-Gespräch, Verständigung zwischen Arzt und Patient, Experten-Laien-Kommunikation, Simulationspatienten, Kommunikationstraining/ -schulung, Interaktionstraining, Aufklärungsgespräch, Beschwerdenexploration, Arzt-Patienten-Verhältnis/Beziehung, Peer Teaching, Kommunikationscurriculum, patientenzentrierte Kommunikation, medizinische Ausbildung, standardisierte Patienten, Kommunikationsfähigkeit, Konsultation.

In addition, we included literature in the review, which we use in our lectures and seminars for medical students since several years at the Technical University of Dresden.
Within the systematic literature review we sought to address certain important questions regarding the training methods themselves, such as the frequency of health communication training for health professionals, the people who deliver the training, and the diverse formats of training implementation. We aimed towards outlining findings and results of different communication trainings, and to identify relevant sources of educational materials for health

communication. These findings shall allow us to design and implement new training courses in the future.
We included scientific and professional reports, articles, books and book chapters, and conference proceedings. Specific topics we are interested in are: the triggers and barriers of patient-doctor-communication; the needs, obstacles and perceptions of patients and physicians regarding health communication; training and educational opportunities for health communication among health professionals; and the best practices for improving health communication among medical doctors.

Results

In the systematic literature review, we identified 91 references that met our inclusion criteria. Of these, we identified six books that provide a general and comprehensive overview of the subject of doctor-patient communication.

Further, several topics were discussed; 21 references reported on triggers and barriers of patient-doctor communication; 17 on needs, obstacles and perceptions of patients and physicians regarding health communication; and 46 focused on training and educational opportunities for health communication among health professionals. Best practices for improving health communication among medical doctors were discussed in 29 literary references. Findings of individual topics are briefly covered below:

Triggers and barriers of patient-doctor communication

We identified books and book chapters, one seminar paper and several articles dealing with triggers and barriers of patient-doctor communication. Most of them focused on both triggers and barriers and gave explicit advice for difficult situations in patient-doctor communication.

Expressing problems, dealing with problems

Empirical data shows that communication is the main tool for physicians. A careful anamnesis alone could lead to correct diagnosis of around half of the cases; with further physical examination 80 % of the diagnoses could be made. Literature shows that about half of the patients are not able to express all of their problems; additionally, many physicians don't pay attention when problems are indeed correctly expressed (Egger, 2007; Geisler, 2003). A particular point of interest in some articles is that there seems to be concrete patterns through which physicians deal with patients expressing feelings and emotions. Feelings and emotions in patient-doctor communication can be manifested verbally as well as non-verbally, and physicians need to recognize and interpret them. This can be hard for physicians when they don't expect such an expression or other relevant activities capture their attention (Fiehler, 2005). Fiehler defined four types of reactions: (1) dealing with emotions and accepting them as appropriate, (2) questioning suitability of intensity or type of emotion, (3) not accepting experience/emotions as appropriate, or (4) passing over and intentionally ignoring to deal with the patients' experience, although it has been perceived and interpreted. Patient-doctor communication was analyzed in a study from Sator, Gstettner & Hladschick-Kermer et al. (2008) where it became obvious that

patients try to point out relevant topics via subtle 'markings of relevance' (verbal and interactive means, e.g. change in volume or way of speaking, use of drastic metaphors or delays in sentences), whereas physicians often ignore these markings and stick to their institutionally formed priorities. In contrast, Siegrist (2003, in Geisler, 2004) points out other main aspects of reactions, which are: ignoring the patient, addressing another person (e.g. physician, nurse), change of topic, or reinterpretation and focusing on subsidiary aspects.

Time pressure

Another problem, also associated with ignoring markings of relevance, is the managing of available time for the physician-patient consultation. An analysis by Sator and colleagues (2008) showed that other things, for example filling in forms, editing documents or communicating among physicians make up over one third of the consultation time. Also the physicians' speaking time is about twice as much as the patients' time to speak (Sator et al., 2008). Examining the relevance of anamnesis, Egger (2007) found that the available time is often not effectively used. Sator et al. (2008) also found out, that ignoring topics that patients come up with, e.g. via markings of relevance, does not alleviate time pressure, as patients try over and over to bring in their issues.

Need for information

There is also evidence that the need for information is much more pronounced than 30-50 years ago. Patients want to be fully informed, especially to be able to participate in medical decisions. Over 80 % of the people that participated in a study wanted to decide about the treatments together with their physician, but only 45 % were able to do so. Empowering patients to become experts for their own disease seems important (Egger, 2007; Faller & Vogel, 2016). In a study by Gaissmaier, Anderson & Schulkin (2014) physicians were asked to imagine two patients, one for whom a specific drug was safe and effective, and one for whom it was not. The study showed that only 25 % of the participants would have given their imagined patients complete and transparent information about benefits and side effects of the drug.

Different focus

It also became obvious that patients and physicians have different aims or topics they need to discuss during consultation. Physicians mainly focus on diagnosing the disease, whereas patients' interests are primarily defined by the experience of the disease (Geisler, 2003). Among cancer patients, the least recognised needs are those related to information on self-help, psychosocial programmes, and experimental studies, as well as support when talking to family members and written summaries of the clinical results (Mehnert, Lehmann & Koch, 2012).

'Doctor language' and cultural language problems

Misunderstandings can also lead to barriers in patient-doctor communication. One problem is that what patients say is often 'translated' into medical terminology, but medical terminology less often into the patients' language. This can lead to patients replying briefly and impersonally

and employing 'doctor language', although physicians and doctors might not understand the same through these medical terms (Geisler, 2003; Wegner et al., 2008). Not only linguistic barriers but also different expectations based on different cultural background can occur. In many cultures the physician is not only an expert, but also a personal adviser, whereas in western countries diseases should be described as short as possible (Wegner, 2008).

Besides these and possibly more barriers in communication, the literature we have found also focused on triggers for positive physician-patient communication, which are described below.

Patient centered communicative behaviors

One approach addresses patient centered communicative behaviors for physicians, nurses and other medical staff, which includes (1) introducing oneself and describing the role in patient care, (2) clear and direct communication, (3) empathy, (4) immediacy, meaning nonverbal affiliative behaviors, (5) listening, and (6) humor and laughter. A study revealed that if health care providers use patient-centered-communication behaviours, especially immediacy and perceived listening, satisfaction with care and with communication increases (Wanzer, Booth- Butterfield & Gruber, 2004).

Active listening

Quite similar is 'active listening' that also includes empathy and understanding, absolute esteem and congruence between the things being said and acted. This can lead to emotional relief, especially for people with severe diagnoses in palliative care. Delivering serious information in a surprising, unfeeling or emotionally impersonal way could have a traumatizing effect on information processing (Schmeling-Kludas, 2006).

Needs, obstacles and perceptions of patients and physicians regarding health communication

Several articles and books present information about patients' and physicians' needs, obstacles and perceptions regarding health communication.
There is a lot of evidence for the existence of basic knowledge of communication. An overview concerning communicative actions during doctor-patient consultation is given in Sprangz-Fogasy's (2005) book chapter.

However, problems are still present during education, as we can see in Nikendei et al. (2012). The article conveys that during the practical year medical students have insufficient time to improve their skills such as to integrate health communication skills in the clinical daily routine.
Lehmann, Koch and Mehnert (2009) focus on the impact of communication on distress, satisfaction and utilization of psychosocial services among cancer patients with regard to patients' communication preferences. Additionally, there are conversation deficits in the context of palliative medicine, suggesting the necessity of 'active listening' as a specific form of

communication (Schmeling-Kludas, 2006). Wilm et al. (2004) found results concerning the physicians' interruption of the consultation, showing that undisturbed consultations might enhance the patient's satisfaction. In relation to the patients' outcome, there is a correlation between perceived interaction quality in patient-doctor interaction and long-term results in rehabilitation, revealing the importance of conversation quality for the rehabilitation success (Dibbelt et al., 2009). Further articles focusing on patients' needs; describe a transformation of the physician-patient communication to a cooperative model, including the patients' participation (Faller, 2012). Similar results are found by Rockenbauch, Geister and Appel (2010), describing an increase in physicians' communication skills by focusing on involving patients as well as on shared decision making; and by Sänger et al. (2007), involving patients in publishing guidelines for National Disease Management. There is also literature characterizing patients' expectations and experiences in health communication that highlights the need for information exchange and balanced decision-making between physicians and patients (Vogel, Helmes & Bengel, 2006). For instance, a cooperation of physicians and linguists focus on cultural expectations, verbalization of medical knowledge, education facilities of doctor-patient communication and psychotherapeutic dimensions (Redder & Wiese, 2013).

As shown in the articles mentioned before, there is a variety of research describing patients' needs and transferring them to a physician-patient communication model.

Training and educational opportunities for health communication among health professionals

Our review of the literature identified a lot of articles, four books, two book chapters, as well as a dissertation, a guideline, a poster and one discussion paper addressing the training and educational opportunities in health communication among health professionals. A study investigated improved communications skills due to training programs in the context of post-graduate education (Bosse et al., 2008). The article by Jünger and Köllner (2003) comes to a similar result, describing that integrated modules that teach doctor-patient communication improve the students' self-efficacy related to communicative competencies. Obviously, the training of health communication and the development of training programs is also relevant at a national level (Jünger, 2015; Kiessling et al., 2010). Additionally, the study by Glenewinkel and Rockenbauch (2009) examines what students think about the health communication by analysing students' web-based training diaries, as a first step to find out what is relevant for this topic.

However, Nikendei et al. (2012) point to a problem, namely that there is not enough time for medical students to improve and to integrate what they learn in their daily clinical routines during the practical year. The study by Neumann et al. (2011) developed a new questionnaire for students to ascertain their opinion about the course and the simulation of patient-physician-interaction. The study highlights the importance of well-designed communication trainings, to make sure that they meet students' needs. In this context, Rockenbauch et al. (2008), as well as Frischenschlager and Hladschick-Kermer (2013) and Kutscher and Seßler (2007) present a guideline for a course in medical education on how to appropriately communicate with patients.

Furthermore, Jünger et al. (2015) analysed how to train doctor-patient communication successfully in medical education.
The practical aspect of health communication was evaluated in Dresden, showing the students' positive evaluations on the training (Köllner et al., 2002). There is a significant learning progress for all measured communication skills in Leipzig as well (Cämmerer, Martin, & Rockenbauch, 2016). Teaching good health communication and learning "soft skills" is important to reduce patients' complaints (Egger, 2007). Furthermore, the Communication Skills Attitude Scale can be used to assess attitudes of medical students towards communications skills (Busch et al., 2015).

With regard to teaching methods which can be suitable for health communication trainings, Bohn (2004) describes neuro-linguistic-programming methods. They were able to increase satisfaction, energy and empathic approaches of practitioners. Furthermore, role-plays and trainings with standardised patients are valuable tools in communication trainings from students' perspective (Bosse et al., 2010), and lead to higher self-efficacy. Rockenbauch et al. (2008) had a further look at the use and advantages of simulating patients in teaching medical and communication skills and show the advantages of learning with simulating patients.

Another idea for a training method is a self-coaching concept to observe, reconsider and enhance communication skills during education and everyday professional life with conventional linguistic methods (Lalouschek, 2004). Kreuter and Wray (2003) emphasize the necessity of tailored and targeted health communication, meaning that success of the training programmes depends on the information's relevance for their intended audience. Consequently, health communication trainings may improve patients' participation by shared decision-making (Klemperer, 2003; Butzlaff, Floer & Isfort, 2003; Rockenbauch & Schildmann, 2011).

Differences between male and female physicians and the countries of origin in the way to communicate with their patients can be found, which may have an impact on a gender-specific and cross-cultural health communication training (van den Brink-Muinen et al., 2002). Further distinctions can be found between patients with different health insurances: in some cases physicians spend more time with the private patients -and earn more money - at the expense of the patients in the public health care system (Mielck & Helmert, 2007).

Finally, there is research on how to evaluate communication competencies in the context of disclosing the diagnosis of cancer to patients (Wand et al., 2008).

Best practices for improving health communication among medical doctors

We identified literature on best practices in trainings for improving health communication among medical doctors; including several articles published in peer-reviewed journals, one poster, books and two guidelines. We found several publications which investigate different practices for improving health communication among medical doctors. Most studies focused on establishing a communication-training program for medical students and on how to successfully

train doctor-patient communication. Main methods included support by web-based training diaries, homepages as well as face-to-face seminars with integrated modules or role-playing.
One study (Jünger & Köllner, 2003) presents the concept, the implementationand the results of integrated modules to teach doctor-patient communication at the universities of Dresden and Heidelberg. The training shows positive effects for students, related to improved self-efficacy.
Rockenbauch et al. (2008) examined the use and advantages of simulated patients (SP) in teaching medical and communication skills as well as information on how to implement these SP-programs. Concrete examples from different departments of Medical Psychology in Germany give an insight into different teaching methods using simulated patients. They also included suggestions for the curriculum and for the necessary resources to help future implementations of SP-programs. Three other papers described the development and implementation of Heidelberg's interdisciplinary longitudinal communication curriculum with innovative topics and strategies (Jünger & Köllner, 2003; Schultz et al., 2007; Sator & Jünger, 2015).
Most of the studies focused on patient-centered conversation. For example, one study (Maatouk-Bürmann et al. 2016) examined that communication training significantly improved patient centeredness during routine clinical practice, which improves the quality of the therapeutic relationship, patient participation and treatment process. Further studies (Rockenbauch & Schildmann, 2011; Zwingmann, Buchholz, Reuter & Keller, 2011) reviewed the topic 'Shared Decision Making' to identify new concepts. Some of them also focused on topics such as involvement of relatives.

Concentrating on students, a few studies (Haberstroh, Neumeyer, Schmitz & Pantel, 2009; Vitinius et al., 2013) focused on caregivers and oncologists. The KoMPASS training program by Zwingmann et al. (2011) aimed to improve oncologists' communication skills. The study showed good reliability for an instrument for evaluating communication competencies in the context of disclosing the diagnosis of cancer to patients (AGBS).

In our systematic literature review, we also identified a poster on learning communication skills in doctor-patient communication during medical education, which gave an overview on aims, methods and evaluation through the students.

One book and one book chapter focused on best training practices for improving health communication among medical doctors. Frischenschlager and Hladschik-Kermer' book (2013) on conversation in medicine contains a guideline for health communication as a part of the medical education. The content of the book chapter (part of a book about psychosomatic medicine by Langewitz, 2011) focused specifically on patient-centered communication. Here, the author made a distinction between patient and doctor-focused communication to achieve the physician's as well as the patient's goals.

In 2015, the Medical Association of North Rhine (Ärztekammer Nordrhein, 2015) published a guideline for communication in everyday medical practice. This guide for practice is an adaption of guide published 2013 by the Swiss Academies of Arts and Sciences and presents an overview of the best communication practices for improving health communication among medical

doctors in Germany. The guide includes general models and basics of communication, a variety of communication techniques as well as specific conversation situations.

Main communication techniques were WWSZ-techniques and techniques from the NURSE Model.

WWSZ-techniques:

Waiting - how to use pauses in a conversation with the patient to get very important information about the patient and his illness, which is important for anamnesis
Echoing - echoing the patients' own words
Mirroring - medical doctor reflects heard words and his perception of the patient
Summarize - to summarize what was said

NURSE-model: Handling emotions

Naming - naming emotions
Understanding - expression for understanding the emotions
Respecting - respect and acceptance for the patient
Supporting - offering support for the patient
Exploring - exploring other aspects of emotions

Further techniques presented in the guide include setting time limits and topics, transfer of information, dealing with divergent concepts, and decision-making.
The meaning of specific situations was well established in the guide. Various specific conversations are discussed and presented.

Examples of specific conversations included in the guide:

Initial clinical interview and anamnesis, communication of bad news, responding to sensitive topics like domestic violence or alcohol consumption, communication with relatives of sick children or of patients with dementia, working with translator, conversation about patient's provision and resuscitation, conversation about treatment errors.

Overall, concrete communication techniques were discussed and have been developed by experts primarily with the aim of conveying promising forms of communication to students and physicians. They illustrate the significance of these techniques for a good doctor-patient communication. However, patients judge the quality of the conversation behavior of physicians not only on the basis of certain techniques, but also on the perceived attitude of a physician, especially if he is committed and competent (Langewitz 2007, Salmon and Young 2005). So, as a measure of conversation quality, it is also important whether the doctor is perceived as authentic (Yedidia, 2007).

Spain

The main objective of this review was to describe the state of health communication in Spain, reviewing the scientific literature about the communication in the health field. The review was performed via a systematic research in different biomedical databases. This revision aims to locate studies, published or not, both in Spanish and English, which have been taken in Spain or include Spain in their analysis about any aspect of health communication, that defines what is the situation or the state of art in this dimension of doctor-patient or nurse-patient relationship. Patients are included as well as the carers in this review. Likewise, the studies that broach the inter-professional communication between doctors and nurses will be included. The studies included could have had any methodological design, qualitative, quantitative or experimental. Any studies which incorporate in the analysis both patients and the carers as well as doctors and/or nurses, in an individual way or compared or a combination of any participants mentioned. The variables of age, gender, ethnic, ancestry, health and education or job position have not been considered.

Inclusion criteria regarding the content of the studies

Studies completed in Spain or those that consider Spain in their analysis will be included in this review. Furthermore, it will be included those studies that brings up the different types of training in health communication, as well as the effect of the communication in different moments of the assistance activity (diagnosis, treatment adhesion, etc.). Studies that address the following will be included: the effect of the communication on health in the behaviors and decision making regarding to health issues; the need and limitation of the communication between doctor-patient, nurse-patient; the damage caused in the sanitary system by a bad communication; those studies that analyze the barriers and facilitators of the health communication related to doctors, nurses and patients, as well as the differences between the different centers and medical specialties. In the same way, it will be included those works which explain the needs and the perception of the patients, doctors and nurses related to the health communication and those that count with statistics data in this issues.

Manual search

As a starting point of this work, before beginning the process of reviewing the literature and in order to identify systematic reviews, clinical trials, clinical practice guidelines and technical reports of major Assessment Agencies of Spanish Health Technology Communication in health, some searches were made through the meta searcher Trip Database. Similarly, in an attempt to identify gray literature related to the subject, it was sought in different repositories on the Internet, such as Open Grey and Dialnet. It also took into account the database of health sciences in Latin America (LILACS). Finally, the repository of doctoral theses, Theseus, was also consulted owing to it includes the references of all theses developed at universities in Spain.

Automatic search

In February 2016, they were conducted several tests on the basis of data Medeline through the OvidSP interface, with the purpose of exploring the various suggested terms and locate others

who might help us to design the final search strategy. Once the strategy was defined, it was translated into the syntax of other databases previously selected, which included Medline and Medline In-Process via OivdSP, Excerpta Medica database (EMBASE) via Elsevier, Cumulative Index to Nursing and Allied Health Literature (CINAHL) via EbscoHost, The Cochrane Library via Wiley, Elsevier Scopus route and finally in The Sciences Citation Index Expanded (SCI-EXPANDED) and The Social Sciences Citation Index (SSCI) via web of Science.

The results were limited to studies published in English or Spanish and carried out from 2000 up to now. In order to recover only those studies conducted in Spain, it was used the Spanish geographic filter validated for Medline, of which syntax was translated to be executed in the other databases used previously. See annexes to view the details of search strategies used and the summary of the results obtained. We searched the reference lists of the studies included to find additional studies.

Reference Management

The references retrieved were imported into Reference Manager v.10, from Thomson Reuters. The duplicates were eliminated through its verification function of duplicates. The remaining registrations were exported to an Excel document to subsequently carry out the selection of relevant studies to this work.

Study selection

It was carried out a first screening by title and summary of all the references retrieved in the different searches. Each registration was classified as "Selected", "Excluded" or "Doubtful", depending on whether they met the criteria for inclusion and exclusion previously defined. Subsequently, in a second screen, the full text of articles classified as "Selected" and "Doubtful" were analysed, to finally select or exclude the studies to develop this work.

Search results:

On the first screen, by title and abstract, were labeled as selected a total of 27 references and 31 as questionable. In a later screen, once analyzed the full text of documents mentioned above, a total of 12 references which were labeled as doubtful or selected in the initial screen, were finally selected, after reading the full text.

Background on Health Communication in Spain

Communication between health professionals and patients is a key factor in the relation established for a treatment (ID_75_26). Patients relate better performance and satisfaction based on behaviors adopted during the communicative relationship. (ID_75_27,28) and they are able to report more and better. In addition, there is a better adherence to the treatment (ID_75_29). It is well known that verbal support, empathy, serenity and focusing on the persons from the psychosocial point of view, are aspects that increase confidence on professionals and enhance therapeutic compliance (ID_75). All of this complemented with nonverbal aspects of communication (ID_1000).

Empathy is a key skill healthcare providers must have in order to ensure the highest quality treatment, however the level of empathy provided is inconsistent, and varies according to a number of factors. A Questionnaire TECA measure of empathy, which measures 4 subscales (empathic understanding, perspective taking, empathic joy and stress empathic) and socio-demographic questionnaire given to 191 students at the Faculty of Medicine of Lleida was used to measure the degree of empathy in medical students in the area, compared with a series of socio-demographic variables and their evolution during medical studies (Esquerda, 2016). In the sample there is a progression of the empathy during the medical courses. Female students show more empathy, apart of more stress empathetic. Male students have less empathy and less progression during the courses and less stress empathetic. The students that prefer the TV program "House" present less empathy, and also the students with family members who are doctors. The students that have done some volunteer work have more empathy as well as those who have had an ill friend. There is no relationship between empathy and specialty (Esquerda, 2016). There are several variables that are related to a higher empathy in medical students: women, students of advanced courses, nearby experiences of serious illness and those involved in volunteer activities.

It is known that there are failures in the information offered to patients for signing the informed consent, as there is most of the time asymmetric information exchange, overprotection and culture clash (ID_841). In other contexts, communication problems may cause adverse effects when taking prescription drugs (ID_94). A descriptive, transversal study based on observation in consultations and subsequent telephone interview of 152 patients of primary care in Toledo assessed the information provided by the doctors and requested by the patient on various aspects of the interview, the assessment of patient participation in decision-making and their satisfaction. (Barca, 2004) The mean age of patients was 41.1 years and the 55.9% were female. The information provided more frequently to the patient, was related to treatment (88.3%). 152 cases were observed in which 55 (36.2%) the patients did not request information. The demand for information to the doctor by the patient when it is not provided spontaneously is mostly about treatment (35.3%) and the cause of the symptoms (29.7%). The 94.0% considered the information received as sufficient. However, the 22.7% said they had left the consultation wanting to ask a question and the 18.6% said having "partially" understood the explanation. According to observers, the 69.4% of patients did not involve in the making-decisions about treatment (Barca, 2004). This study indicates that the information that the doctor provides is not as complete as it should. The patient does not ask the patient as many questions as they should. A high percentage of these patients are eager to ask questions or do not fully understand the information, yet are not sure how to do so, resulting in low participation.

It is also critical for carers to be actively involved and informed in order to ensure the best success of the therapy. A qualitative descriptive study using semi-structured and open interviews of 12 main carers of patients with an implantable cardioverter defibrillator (ICD) attempted to discover the needs of carers' of patient with an ICD during the hospitalization in the Coronary Care Unit of the Hospital Virgen Macarena and after hospital discharge (Alvarez-Leiva, 2007). The study concluded that attention to the needs of information and emotional support of the family should be included in the planning of the patient care. It should also be included the participation of the nurses in the process of transmitting information about DAI and its possible

complications (Alvarez-Leiva, 2007). This would allow progressive and personalized information in order to prepare a high adjustment to the new situation. It should be modified the duration of visitsr schedules depending on the circumstances of each patient and family. It would be necessary to implement strategies that promote communication among caregivers and nurses.

Bad news bad delivered in hard moments may cause more perplexity, suffering, and anger to patients. However if properly notified, it can help understanding, acceptance, and reconciliation. Communication training may improve perceived quality of care and it may have a demonstrable direct effect on health outcomes (ID_1068).

Communication can also be influenced by external, systematic factors. The doctors perceived a relationship between poverty of health resources (limited time for consultation, excess burden of care, lack of specific resources, and lack of training), the conflict with "difficult" patients, and the influence of psychosocial factors in the clinical encounter with the error, wear, defensive medicine and the low quality of services (Giron, 2002). The results of several focus groups involving 24 doctors and 22 patients studied the relationship between the quality of the doctor-patient relationship and the results of clinical encounters in primary care. This relationship was mediated by communication problems/exploration in the clinical interview and by negative feelings. Patients perceived a relationship between the functioning characterized by overcrowded and short-term consultations and communication difficulties in doctor and patient, with the error and conflict in the clinical encounter. Better health outcomes are therefore mediated by a physician with a more humanistic attitude. The objectives and priorities of the health system are away from the needs of the community and are seen as determinant key of the inadequacies perceived (Giron, 2002). The processes of doctor-patient relationship play a mediating role between health resources and outcomes of clinical encounters. The improvement of the attention and the doctor-patient relationship in primary care requires a multidimensional performance that goes beyond the interventions on individual factors of both doctor and patient.

Additional external factors are theorized to influence health communication. There is evidence to indicate that demographics, such as age and location influence the level of satisfaction patients have with their healthcare providers. A cross-sectional study through interviews and The Patient-Doctor Relationship Questionnaire (PDRQ-9) surveyed 451 patients from six primary care centers in the Community of Madrid, randomly selected. The average level of satisfaction was 4.41 (confidence interval [CI], 95% 4.33 to 4.48) on a scale from one (least satisfied) to 5 (high satisfaction) with a median of 4.78 (interquartile range: 4.00 to 5.00). Four out of 10 subjects expressed the maximum satisfaction (ceiling effect). Only one factor explained the 75.3% of the variance, with a Cronbach of 0.952. Age (OR: 1.03, 95% CI: 1.02 to 1.05) and living in rural areas (OR: 1.44, 95% CI: 0.94 to 2.20) were associated with higher satisfaction (Martin-Fernandez, 2010). According to the results, patients who are older and those who live in rural areas are generally more satisfied with the quality of their relationship with their physician.

The increased use of the internet as a tool for accessing health information has also had a notable role in influencing doctor-patient communication. A survey of 74 oncologists pediatric and 110 parents of children with cancer examined the use of Internet by parents of children with cancer, to obtain information and the role of this information in the relationship between them

and doctors. Less than the half of parents surveyed (44.5%) sought information on the Internet, while the 55.5% prefer not to do it. In addition, the 87.3% of parents explain that their doctors do not recommend any website. Among oncologists, the 68.9% of respondents did not recommend finding information on the Internet, but would like the patients to be guided on the search (82.4%) (Dominguez M, 2012). It became clear the need to improve the communication parents-doctors, because of the evidence of the difference between the need of the parents to get information about the disease of their children and the opposition of oncologists to uncontrolled access to websites over the Internet (Dominguez M, 2012). It is necessary that health professionals guide the search of information on the Internet for patients and families In the same way, they should be sure that the family have correctly understood the information received, taking into account the cultural level and understanding of medical information, which can vary depending on the patients and their families. The study provides reliable indicators of the type of information the patients and their families want and how to access to it (Dominguez M, 2012).

A second cross-sectional study of patients of a health center of primary care located in Madrid collected 323 questionnaires of patients between 14 and 75 years that go to doctor's appointment for any reason, except illiterate patients or those with neurological or psychiatric problems that prevented them from answering the survey. The survey indicated that 61% of patients have used the Internet as a source of health information (Marin-Torres, 2013). Internet responded to health concerns to the 92.4% of internet users. The 53.5% reported that internet ever changed their way of thinking about health and the 30% performed some change in behavior; the 60.1% told these changes with their doctor. The 44.3% reported more questions in consultation and the 80.8% believe that their doctor would be willing to discuss the information found on the Internet (Marin-Torres, 2013), concluding that use of the Internet to consult health information is very common, with positive influence on the doctor-patient relationship. It may be useful to achieve behavioral change and use it as an ally in the query.

Within health sciences, each discipline has its own communication culture, own moral values, and different but complementary healthcare needs perspective (ID_980). Nurses, despite their assumed inherent superiority in communication due to their roles as caretakers and increased contact time with patients, are also important to consider with regards to improving their communication skills. A mixed methods study with 237 patients from Andalucia assessed the preferences, satisfaction and the degree of patient participation in the decision-making process with nurses in health center (Moral, 2011) the 59% of patients (138) preferred a collaborative role with the nurse when making decisions. The 96.2% (228) of users surveyed said they were satisfied or very satisfied with the decision-making process in the nursing. However, the 17.4% (41) made suggestions for improvement. For patients, the main areas of improvement were related to communication to help decide, agree or make advice skills. This study concludes that nurses should be aware that more than half of their patients wish to participate in the decisions made in consultation with their nurses. In the practice, this participation can be improved by incorporating specific communication skills. Surveys that incorporate open-ended questions allow detect more accurately the problems of care (Moral, 2011). Leaders of the different healthcare professions should promote initiatives to promote the work in a multidisciplinary

team focused on maintaining and developing a good relationship with patients from the communication point of view.

Health care professionals express a need to improve in communication techniques with patients in complex circumstances, as for example, people at the end of their lives and their families (ID_305). A multicenter and national study of 61 doctors and 679 patients without restriction of sex or age, diagnosed with EA, who come with their carers to medical consultation to control or monitor the disease, with direct responsibility of professional and clinical follow-up information to their carers evaluated the information provided by the doctor and retained by the patient in 17 informative aspects and the factors associated with the difference in perception of the transmitted information. (Molinuevo, 2012) Results of the study noted that carers rated significantly better the information received on: concept of disease, pathogenetic aspects, dosage and recommendations on treatment and therapeutic adherence. Doctors considered significantly better the information concerning to demystification and correction of previous conceptions, possible complications, risks, adverse effects and / or iatrogenic, family associations, and emotional / psychological support to carers ($p < 0.05$). The agreement on the information provided and received was between poor and weak (Kappa ≤ 0.27). The degree of disease progression (GDS scale) was a significantly factor associated with professional-carers discordance ($p = 0.002$) (Molinuevo, 2012). This indicates the differences in perception between doctors and carers of patients were seen with Alzheimer's disease for many informational aspects, bringing up the need to improve the communication process to optimize its quality.

Training is an essential component to improving professional´s communicative resources. A Delhi Survey of 129 professionals, including doctor of primary care, nurses, technicians and people responsible of the primary care attention and public health professionals in Catalonia indicated the importance of knowing the views of primary care professionals on preventive activities in clinical practice, as well as the obstacles perceived by professionals to perform them and the possible ways to overcome them (Nebot, 2007). After two rounds were conducted, in which response rates of 48.9 and 67.4% respectively were obtained. After the second round it was obtained a convergence over 40% in all questions. The main problems for prevention in practice were the lack of time and their own attitudes of the professionals towards the prevention. To improve the implementation of prevention in practice, professionals noted the communication skills training, advice methodology and the use of clinical practice guidelines. The professionals suggest some specific needs in training that can help to improve the integration of preventive activities. On the other hand, it has been detected the need to improve the attitudes of the professionals themselves towards prevention (Nebot, 2007).

A randomized single blind study of primary healthcare physicians of primary evaluated the effectiveness of a training program for primary care physicians in Spain (Moral, 2001). The intervention group received a course 18 hours. First they tried to reach agreement with doctors about: the main characteristics and presentation of the clinical problems most common primary care; the importance of psychosocial aspects involved in the reasons for patient care; and the general objectives and the best strategies to meet in a query. A general scheme for the similar to that proposed by other authors' consultation was found. These aspects were highlighted by watching videos as an example. We also include information on the scientific evidence of the

effectiveness of various communication strategies usually employed. They practiced communication skills to: (i) the establishment of an effective relationship; (Ii) obtaining information biopsychosocial; (Iii) provide information and negotiation; and (iv) the closure of the interview. We use role playing, recorded interviews selected as models and as a "trigger" video, and feedback. Finally, an interview with a simulated patient "was performed by all physicians, following individualized information by the facilitator (Moral, 2001).This study shows that physicians improved the use of strategies and skills to carry out consultations focused on the patient after receiving an interactive course in both patient assessment after immediate and standardized intervention on an assessment by their real patients. Moreover, the gain immediately after the intervention was completed was observed, and after running for a variable period of time, up to 1 year (Moral, 2001). Role-playing is one of the existing methodologies to teach communication skills. In recent years awareness of the need to implement educational improvements with regards to health communication in undergraduate and graduate level has raised (ID_898).

A study from the University of Navarra with students in the fourth Grade in the elective subject of Palliative Care of Nursing Degree assess student perceptions on the use of role-playing as a method of teaching, aspects for improvement and evaluation of resources used to prepare the sessions. After this experience with students of Nursing Degree, we can conclude that the role-playing is very useful to acquire communication skills with people of Palliative Care. It also promotes the development of skills and attitudes to face difficult situations in communication (Sanchez Fernandez, 2016). These results support the recommendations of the European Association of Palliative Care using different teaching methods such as role-playing, for training in palliative care. Therefore, continuing using the method of role-playing with Grade students will help them to cope with more security, complex communication situations in clinical practice. They will be better able to treat people with advanced illness and in the end of life (Sanchez Fernandez, 2016).

Discussion

Overall, we can say that, of the 12 studies included, 11 of them had a qualitative design, while 1 was experimental. The methodology used in 5 of them was the survey; one used the questionnaire with open questions and 2, the interview. 2 were observational studies, one used the methodology of focus group and another one conducted a single-blind randomized trial. Finally, we should mention that one of the studies used the methodology of role-playing, although it is a letter to the editor, the authors simply tell the experience without providing specific details regarding the design and study results.

Related to the specialties, we have found that are mainly studies conducted in primary care. Thus, 6 studies were developed in primary care, 2 in specialty care that included specialists in oncology and neurology and 1 which included a sample of specialty doctors, although the authors did not specify the specialty and primary care doctors. Finally, 2 studies based their sample on nurses and 2 on nursing and medical students respectively.

From the beginning, man has searched for help from their peers to solve their health problems. Some groups specialized in the health field attending to personal attributes or vocation. These

groups based their interventions in empiricism and afterward it led to investigation based on a healer-healed´ therapeutic relationship. This relationship needed a human interaction that sometimes was simple and sometimes was complex, as human beings are. Empathy plays a key role in this context as it helps healer to understand the sick persons to overcome the difficulties they are facing. In this frame of references is where human communication mediates the interaction between professionals and patients around health behaviors.

According to Lomonosov et al. (1989) "El problema de la comunicación en Psicología", Ed. C. Sociales, Habana. Communication, of any kind, is any process of social interaction through symbols and message systems, includes any process in which the behavior of a human being acts as a stimulus for the conduct of another human being.

But, are we communicators from the day we were born or is it something we learn? It has been proved that we are born with attributes that facilitate proper communication what is added to other abilities that we acquire through the learning process in life.

Both, social abilities and communication skills are essential tools for the development of the health care activities of health professionals, allowing the necessary improvement in health habits of healthy and ill patients.

When we explore and analyze the curricula of Spanish health professionals we found out that it has not been given the required importance to this topic. All of this comes clear after the review conducted by the Spanish group confirming the small amount of papers that addresses the issue. Scientific production is mainly centered in a marked concern of professionals focusing the work on the role of communication in the process of the therapeutic relationship and user satisfaction.

Professionals often search for enhancement in training with methods like role-playing and studying basic theoretical contents about communication techniques, pretending so to fill the gaps in their academic training.

Undergraduate training of Spanish health professional requires postgraduate instruction and continuing education to improve the communication between peers and with users of the health system. Only exceptionally, we find postgraduate training that tries to balance this kind of preparation.

Poland

Introduction

The literature review report arises from the need to analyze and present situation concerning health communication among health care professionals and focuses on review of available literature in Polish. The search for information was performed with taking into account the guidelines provided by the activity leader, particularly focusing on the following information:

- health communication skills of health professionals (physicians & nurses) in Europe;

- effect of health communication on different situations in health care (e.g. Patient-doctor relationship, diagnosis, adherence to treatment); how information available through the media (e.g. internet) affects health professional - patient communication;
- good practices in the area of health communication education for health professionals;
- sources of information/training;
- needs, obstacles and perceptions of health professionals and patients regarding health communication.
- the number of physicians & nurses in your country/in the reviewed country
- the number/percentage of Physicians having received health communication training in your country – if this information is available
- the number/percentage of Nurses having received health communication training in your country – if this information is available

The literature review for the purposes of the H-COM Project was performed with an assumption that only Polish part of all available materials was analyzed, i.e. materials either published in Polish language or by Polish authors. In this literature review only materials published from the year 2000 onwards were taken into account. The results of identification focused on the Polish language literature may be divided into the following sections:

- Published scientific articles
- Published books and handbooks
- Information and articles published on-line
- Information about courses and conferences

Background information about health care in Poland

According to the latest available official national statistics, as per the last day of 2014 there were 141 390 physicians, 40 110 dentists, 31417 pharmacists, 282 472 nurses, and 35 468 midwives who were entitled to practice their profession. Regarding those who are practicing, in 2014 there were 87 687 physicians (2.3 per 1000 population), 13 088 dentists (0.3 per 1000 population), 27 747 pharmacists (0.7 per 1000 population), 199 188 nurses (5.2 per 1000 population), 22 381 midwives (1.1 per 1000 population), and 24 594 physiotherapists (0.6 per 1000 population) (Source: Statistical yearbook of the Republic of Poland 2015, Central Statistical Office, Warsaw 2015).

Published scientific articles

Apparently, health communication and related topics are not very popular among Polish researchers, as very few published articles are available. Taking into account the period starting from the year 2000 onwards, the research team managed to identify 10 relevant articles (they are enumerated in References section).

The great majority of articles are review papers, with information from other sources summarized and concluded according to the topic. Only one paper can be regarded as somehow original paper; however it is still more of review character.

As it seems, only in the last few years the topic of communication in health care has been discovered by the Polish researchers and studied more in-depth than in previous years. However the information on the topic in professional scientific journals is still scarce.

Principles of good communication between patient and medical staff according to Polish researchers

Authors stress that good interpersonal communication is of supreme importance in medical care. There is a clear and positive relationship between good communication with patients and the advancement of the treatment (Motyka 2010, Kaźmierczak 2011, Kowalska et al. 2011, Czerw et al. 2012, Sobczak 2014). According to Motyka, the precondition of good communication with patients is the proper proportion of object surface, related to the characteristics of medical care actions taken and the subject plane – related to the characteristics of the sick person's consciousness, his or her thoughts and feelings. Just a few words or king gesture may have a huge positive impact on patient's perception of the care provided. Not only verbal communication is important – also non-verbal communication has great importance (Motyka 2010). Also Kaźmierczak stresses the importance of both verbal and non-verbal communication in the treatment process (Kaźmierczak 2011).

Kowalska et al. (2010) claim that communication between physician and patient has three important functions: informative-diagnostic, persuasive, and therapeutic. Citing concept of T.S. Szasz and M.H. Hollender they remind that there are three basic types of interaction between physician and patient: activity-passivity, directing-cooperation, and mutual participation. Currently recommended model of cooperation has following characteristics:

- Patient is the central point of mutual relations
- Contact between physician and patient is based on mutual respect, trust and respecting autonomy,
- The main principle is care after patient,
- Patient is an active participant of the treatment process,
- Physician can and wants to listens to the patient and has ability to effectively communicate.

Dignity of man as a human being gives an individual full right to be informed concerning the diagnosis and prognoses. Thus, it is the duty of a physician to provide a patient with true, genuine medical information, unless a patient expresses otherwise. The conversation with a patient should leave him/her hope and assure a conviction that he/she may count on assistance and support on the part of medical staff (Kowalska et al. 2010).

Other conclusion drawn by authors is that good communication may have a positive impact on patient's perception of fear and anxiety related with curative process, also may diminish anger and aggression related with fear (Kaźmierczak 2011).

A separate issue is communication with patients with special needs or in special medical conditions, like cancer or terminal diseases. Kowalska et al. (2011) claims that "*Skillful and efficient communication between a medical professional and a deaf/ deaf-mute patient constitutes the foundation of mutual relations between them; therefore, it is extremely important to pay attention to the need for educating medical staff in an efficient use of sign language. In many countries worldwide, the problem of communication between a medical professional and a deaf patient is still present and requires the undertaking of concrete organizational actions in order to provide the deaf the possibilities of fully-fledged use of medical care. One of the forms of counteracting the communication barriers present at each stage of providing medical care, especially in urgent situations, is the education of medical services in the essentials of sign language. The main incentive for undertaking considerations concerning the problems of medical professional-deaf patient communication is paying attention to multi-aspect problems experienced by the deaf in association with everyday functioning in the environment of those hearing, and proposals of specific legislative changes aimed at the provision of deaf/deaf-mute/deaf-blind patients with the sense of safety and possibilities of fully-fledged use of public health care institutions.".*

Jankowska refers to patients with cancer and delivering bad news to patients, which is particularly difficult part of medical profession. She stresses importance of empathy in doctor-patient relation ("*The right diagnosis disclosure in pediatric oncology is a particularly difficult task for the doctor and it is often an emotionally exhausting experience"*). In her paper, the author presents a protocol for communicating bad news adapted for pediatric oncology purposes, developed on the basis of a review of the literature, the experience of the Pediatrics, Hematology and Oncology Clinic of the Nicolaus Copernicus University in Torun, and conversations with patients. It is based on an acronym of a word EMPATIA (which is "empathy" in Polish). "E" stands for "emotions", "M" – place, people and time, "P" – level of knowledge and preparedness of patient, "A" – adequate, appropriate language, "T" – the message (its contents), "I" – additional information, "A" – remarks, additions in medical documentation. Author assumes that EMPATIA protocol will allow physicians to communicate bad news to patients in an easier way, allowing baking basis for further good cooperation (Jankowska 2014).

Similar topic is touched by Sobczak in his paper from 2014. He mentions three models of notifying news: direct information model, limited information model, and negotiating information model. In the article, author refers to SPIKES Six-Step Protocol (Setting, Perception, Invitation, Knowledge, Emotions, Strategy) (Sobczak 2014).

Models of communication between physician and patient are well described in a paper by Zembala. The author refers to paternalistic model, partner model, systemic-partner model, explaining their principles and marking differences between them. Additionally the paper refers to other models of communication, like – already previously mentioned – "activity-passivity", "directing-cooperation", and "mutual participation" (by Szasz, Hollender). Also "Somatic

approach" and "General approach" to building patient-doctor relation developed by Kuczyńska is mentioned in the paper, as well as models proposed by Pierloot: "communicative model", "socio-cultural model", "model of medical transfer of doctor-patient relation", and "friendly model of doctor-patient relation" (Zembala 2015).

Czerw et al. in their paper mention difficulties in doctor-patient relation, including: communicating bad news, contact with child patient, lack of patient's cooperation. Another important issue is quality of service provided at the registration or reception in medical facility. Authors refer to facilitators in communication, such as "automatic communication", use of e-mail, text messages, tele-medicine (pre-ordered, real-time). The proper communication, both inside the facility and with external entities, is considered an important factor determining success of each organization (Czerw et al. 2012).

Meller and Milik in their paper from 2014 summarized information on marketing communication in healthcare enterprises available in literature sources and presented them in a brief summary. The paper is a typical review article being synopsis of different papers, however may be useful for a person who is not familiar with the topic of communication as a good start point for deeper search.

Another paper presenting a general overview of the topic is the one by Deręgowska (2015) who presents various background information on communication theories. The author stresses also that "t*eaching communication skills to healthcare professionals is absolutely essential and should be carried out according to the latest knowledge and standards developed in many countries".*

Comment on other sources of information

Apart from papers mentioned above, there is some additional information regarding medical communication that may be found on the internet. However these are not resources with very detailed knowledge or in-depth analyses of the topic. They may be useful for someone who would like to get slightly familiar with the phenomenon, but limited in terms of providing wide, versatile pack of information. Among these resources there is such a Facebook profile, blog or websites with short articles:

- Facebook profile of the Polish Association of Medical Communication: https://www.facebook.com/Polskie-Towarzystwo-Komunikacji-Medycznej-730138437075843/
- KOMUNIKACJA INTERPERSONALNA. Jak rozmawiać z pacjentem diabetologicznym? Informacje dla pielęgniarki: http://www.pfed.org.pl/uploads/1/9/9/8/19983953/broszura_komunikacja_interpersonalna_p2.pdf
- Short information on how to communicate with patients: http://www.neomedica.pl/newsView,20,Komunikacja-pomiedzy-lekarzem-a-pacjentem,PL#art

- Blog for people interested in medical care. The below mentioned entries concern basics of communication, both in general and medical care approach:
    - http://www.opiekunowie.eu/2014/11/komunikacja.html
    - http://www.opiekunowie.eu/2015/01/umiejetnosc-komunikowania-sie-staa-sie.html
- An interview with Hanna Hamer, PhD in social and clinical psychology, lecturer, on issue of doctor-patient communication. Published on-line on website of Gazeta Lekarska, and in *„Gazeta Lekarska" nr 4/2015:*
  http://www.gazetalekarska.pl/?p=14237
- Another general on-line article on communication between physician and patient:
  http://medium.dilnet.wroc.pl/index.php/kwiecie-2015/732-sztuka-rozmowy-podstaw-diagnozy-puapki-komunikacji-interpersonalnej-w-relacji-lekarz-pacjent
- Brief information about training programme (e-learning) developed in the USA by Astute Doctor Education together with one of service providers – MGIS, regarding good communication issues. In conclusion, author mentions need for similar training in Polish conditions:
  http://blog-med.asecurama.pl/569-komunikacja-z-pacjentami-czyli-jak-to-robia-na-zachodzie
- Website with information regarding issues of doctor-patient communication. Currently under construction (re-construction after hackers' attack):
  http://komunikacja-medyczna.pl/

Besides the above, the Polish Internet contains information about conferences or training organized by different bodies that are related with medical communication area.

Taking into account non-Internet source, there are books and handbooks available regarding the issue of communication. Some are more and some are less focused on medical communication, and some only mention issue of communication among many other subjects described in the volume. The most recent books more focused on medical communication are listed below:

- Marta Makara-Studzińska: Komunikacja z pacjentem [Communication with patient]. Published by Czelej, 2012, ISBN: 978-83-7563-133-3
- Tomasz Goban-Klas: Komunikowanie w ochronie zdrowia - interpersonalne, organizacyjne i medialne [Comminicating in health protection – interpersonal, organizational and media approach]. Published by Wolters Kluwer SA, 2014, ISBN: 978-83-264-3346-7
- Jan Doroszewski (ed.), Marek Kulus (ed.), Andrzej Markowski (ed.): Porozumienie z pacjentem. Relacje i komunikacja [Understanding patient. Relationas and communication]. Published by Wolters Kluwer SA, 2014, ISBN: 978-83-264-3364-1

- Andrzej Steciwko, Jarosław Barański (editors): Porozumiewanie się lekarza z pacjentem i jego rodziną [Communication between physician and patient and patient's family]. Published by Elsevier Urban & Partner, Wrocław 2012, ISBN: 978-83-7609-455-7

- Beata Tobiasz-Adamczyk: Relacje lekarz – pacjent w perspektywie socjologii medycyny [Relation physician-patient in a perspective of sociology of medicine]. Published by Wydawnictwo UJ, Kraków 2001, ISBN: 83-233-1518-3

Summary and General Findings

Health Communication is of critical importance today. As medical practice continues to shift away from the traditional paternalistic model and towards a more patient-centered approach, it is necessary to understand the benefits of and barriers to effective doctor-patient communication. Over the past twenty or so years, researchers have provided conclusive evidence that good communication between the medical provider and the patient has numerous beneficial health outcomes. Health Communication is based primarily on information giving and empathy. Information giving describes the process in which the physician is able to effectively communicate diagnoses, therapies, and recommendations to the patient in a way in which the patient has a full understanding. Empathy relates to the ability to form a relationship between the medical provider and the patient so as enable understanding of the patient's personal context and understanding of their medical concerns and thus adjust and individualize treatment. Employing these aspects of health communication effectively has shown to reduce hospital readmissions, improve adherence and improve patient satisfaction. Ultimately, improving health communication could have a significant health and economic impact.

The barriers to effective health communication are complex, often based in social phenomena or pre-existing systematic structures that require comprehensive and integrated approach. One of the most important systematic barriers to health communication is the lack of emphasis on physician-patient communication courses in medical school curricula. While this has steadily been changing over the years, particularly in the United States, United Kingdom and German-speaking countries, there is still a lack of systemic reinforcement of communication skills throughout medical studies, particularly in the final years and residency when students interact directly with patients. Specific specialties which handle patients with chronic or terminal diseases (i.e.: gerontology and oncology) would highly benefit from these skills as they require the delivery of emotionally and psychologically delicate messages. Since the change has been so recent, there is still an educational gap between generations of medical practitioners, resulting in a lack of role models who practice and excel at formal communication skills. Additionally, once practicing medicine, even physicians who are trained in communication techniques are constrained by a lack of time—usually due to heavy workloads and increased number of patients. Ultimately, this informs a larger institutional framework that generally does not support and encourage the use of communication techniques in medical practice.

Many of the socially driven barriers may be more difficult to tackle, as they require medical providers to become sensitized to sociocultural issues which affect their patient population.

Cultural competency, for example, is a skill many doctors lack for a variety of reasons. Namely, today's increasingly global society has increased the likelihood that a physician will encounter a patient culturally linguistically different to them. Innate biases reveal themselves during consultation, and misunderstandings (both verbal and non-verbal) arise often making communication prohibitive or ineffective. Similarly, an increasing academic focus on researching health literacy has indicated that since the majority of patients are not educated in medical terminology. Physicians are not trained to understand the educational discrepancies between themselves and the patient and ultimately attempt to transmit information during consultation that the patient is not capable of understanding. In both instances, physicians must be aware of the specific needs of their patient population and the barriers that affect them directly and be provided with the skills to be able to adjust language and behavior in order to promote clarity and understanding.

There are differences in Europe as to the extent health communication is targeted as important and starategies are implemnetd for its improvement. In the UK and other EU countries such as Germany academic bodies and medical institutions have worked toward implementing and standardizing and emphasizing physician-patient communication in medical school curricula. German-speaking medical schools have also taken important steps in creating a standardized ideoplogical and technical framework with which to continue developing medical school curricula. While there are often communication courses in many European medical schools, they are often elective courses, or poorly reinforced over the course of the students' medical school career.

In the United States emphasis on health communication has come in the wake of health reform which is structured around patient-centered care, further suggesting the importance of national policy in shaping the culture of medical practice. The US has also set a model example of the power of larger institutions such as universities and health maintenance organization to create an implement training modules on a grand scale. This is due in part to their greater funding capacity, in depth knowledge of health theory, and expertise in collaborative projects. Many have been successful in creating training programs for practicing physicians and continuing education through the creation of targeted theory and skill based training sessions.

Following the best practices these existing programs have established, it is possible to create training modules for European healthcare workers and adapt them to the specific needs of their native populations. It is necessary to do need-based analysis of current social conditions in Europe with regards to health communication and tailor programs according to what is relevant to physicians in EU Countries. Broadly, it is equally as important to create a greater culture supportive of health communication which demands higher quality of physician-patient relationships.

Health Communication in the H-Com consortium countries

While the evidence about the effectiveness of health communication is adudent in the literature there is lack of data about the current state of health communication in the consortium countires with the exception of Germany.

If health communication is mentioned in the literature, it is often a byproduct of discussing patient satisfaction. However, there are gaps in the literature specifically addressing barriers, facilitators, and recommendations for training programs. Throughout the country reports, it is primarily significant to note that there is a lack of patient satisfaction in their level of care and communication. Country reports indicated that there are the beginnings of a shift towards an awareness of the patient-centered model and its benefits for overall patient wellness. However, most of this insight has yet to be fully put into practice at an institutional or systematic level. The research that has been conducted on physician-patient communication has identified a number of important themes.

The findings of almost 100 references shows that there is already awareness and re-think to this issue in Germany. The German literature search reveals the high level of publications, containing a variety of concrete methods and examples for improving the communication in health care settings. Specific topics of doctor-patient communication were discussed in several publications. Further, a few books provide a general and comprehensive overview. Overall, literature offered many training opportunities for medical students, but there is still a lack of transfer to continuing education for all health care professionals. However, the published literature reflects only a small part of reality in Germany. A lot of trainings for physicians are taking place and various methods for improving the doctor-patient communication are applied (e.g. in teaching) without being adequately documented. On the other hand, concrete methods, which are described in the literature, are not sufficiently implemented in practice (e.g. in teaching, further education).

Much of the evidence discussed in the country literature reviews indicates that there are important systematic and logistical barriers that ultimately influence the quality of physician-patient communication. It is widely agreed upon that physicians and nurses have a physically, mentally, and emotionally demanding job which already makes communicating difficult. Often physicians and nurses are overburdened, have a large number of patients to attend to, and ultimately have little time which they can dedicate to fully explaining therapies to patients. However, this is exacerbated in countries facing economic crises, particularly in Mediterranean countries, where budget deficiencies have resulted in poor resource management and understaffing, increasing undue burden on HCWs. This again reduces the amount of time HCWs have with their patients, limiting the amount of information patients are able to receive as well as limits the time patients have to ask questions about their recommended therapies and ultimately followed as prescribed.

It is interesting to note that Cyprus was the only country to dedicate a significant portion of their review to the impact of poor health literacy on physician-patient communication. This is particularly difficult when the knowledge gap between physician and patient is so broad, with messages often delivered with vocabulary beyond the level of understanding of the patient. Health literacy is indeed important to address as the average European citizen has limited knowledge of health and health management. However, there is additional commentary generally also supporting the theory that patients—in addition to lacking the levels of literacy required to follow through with care—are also generally disempowered during medical consultation. The reviewed literature contains gaps in how to remediate lack of patient understanding and empowerment, indicating that further research could be done to address

specifically the role doctors play in adjusting their language and behavior to meet the needs of their patient population and promoting patient self-efficacy.

Participant countries noted in their reports that there is a widespread deficiency in training, both within the medical curriculum as well as available continuing education for practicing HCWs, albeit the extent to which they need improvement varies among the partners. Only in Germany health communication training during the studiesa are mandatory and regulated in the licence to practise medicine. Partners note that when communication is offered in medical coursework, it is offered often as an elective, early on in medical training as a single module, and is not reinforced throughout the entirely of one's medical education. One longitudianal curriculum was implemented at the Faculty of Medicine in Heidelberg, Germany (Sator & Jünger 2014). Countries such as Greece and Spain note that this may be the result of a cultural norm in which communication is a character trait as opposed to a learnable skill. This is likewise for empathy, possibly justifying the lack of a targeted focus in training for communication and interpersonal skills. Countries reported the need for ongoing communication education for medical providers as well for continuing reinforcement throughout their medical career, with an additional focus on evaluation techniques incorporated systematically into these trainings. Additionally, courses in communication should stress the importance of adapting communication to specific circumstances in which clarity and interpersonal communication are more sensitive and imperative such as cancer care or end-of-life treatment.

The synthesis of the reports indicates primarily that more research and investigation regarding communication between patient and medical provider should be developed at the larger, EU level specifically. These literature reviews illuminate a general lack of focus on assessment and development of projects targeting the theme of this report: that dissatisfaction is present, substantive training opportunities scarce, and that structural support for increased understanding between physicians and patients is imperative.

Implications for training

The literature review has provided a plethora of important aspects which will inform the development of the H-Com training curriculum. As indicated by research findings health communication has a positive effect on treatment outcomes, adherence to treatment, hospital admission rates and patient satisfaction. Health communication training for doctors and nurse should emhasise empathy and provide practical training especially regarding patients from hard to reach populations. In addition, research showed that most EU countries have short cosulatation sessions hence training in time management is important for both nurses and doctors. Training should focus on how to obtain and deliver the important information within a short time frame and which questions should be asked and answered so as to ensure adequate understanding of the treatment protocol. Other important aspects which training should consider are cultural competency especially in view of the very diverse cultural environment in Europe as well as understanding and adequately addressing and responding to the needs of patients with low health lietarcy. Finally, the literature showed that in the last years there is a need to address the plethora of medical information accessible to the public through the

internet. Health care professionals need to respond positively to information seeking behaviours of their patients and adequately advise so as to address misconceptions.

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