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Editorial

From primary care interventions to classical communication studies: Papers from the EACH 2006 conference

1. Introduction

The EACH conference in Basel was a good chance to bring together 418 researchers, teachers, and clinicians of various professional backgrounds from 39 different countries, including a large delegation from Iran with 16 members. This issue of PEC presents papers based upon invited lectures and a selection of the best oral and poster presentations, covering some of the many important topics in health care communication, such as primary prevention, cultural factors, qualitative approaches and non-verbal communication.

2. Primary prevention

Salmon [1] in his invited lecture presented his view on conflict, collusion or collaboration in consultations about medically unexplained symptoms (MUS): The need for a curriculum of medical explanation. He described the basis of the communication problems that characterise consultations about medically unexplained symptoms and identified implications for clinical education. Recent research into the details of clinical communication about MUS was reviewed narratively and critically, and broader research literature was scrutinised from the perspective of a practitioner who wishes to provide less frightening explanations for physical symptoms. Consultations about MUS often involve contest between patients' authority, resting on their knowledge of their symptoms, and practitioners' authority, based on the knowledge of normal findings of tests and investigations. Contest is a product of patients and practitioners occupying separate conceptual 'ground'. Avoiding contest requires the practitioner to find an area within which each party can understand and discuss symptoms. Simple collusion with explanations that patients suggest can damage a clinical relationship and lead to unnecessary investigations that in turn corroborate patients' belief in the organic nature of their complaints. Although practitioners are often faced with this task, this aspect of their professional role is not greatly valued amongst practitioners or in medical curricula.

In a study on *Preventing without stigmatizing: The complex stakes of information on AIDS*, Coppola [2] evaluated the

impact that the marking of the argumentative orientation and the temporal framing of HIV incidence can have on the intent to adopt preventive behaviour and the attitude towards the fight against AIDS. A text was presented as an epidemiological information message about HIV/AIDS in which the marking of the argumentative orientation (high marking versus low marking) and the framing of the HIV infection (yearly estimates versus daily estimates) was varied. Subjects were asked to read it carefully and to answer questions about their preventive intentions and opinions as regards the fight against AIDS. High marking of the argumentative orientation and daily estimates increase the subject's preventive intentions but also reinforce their support for a coercive management of the epidemiological situation. These results are discussed within the framework of critical studies on mass media and on studies discussing the links between experienced stigmata, stress and psychological distress.

Mackay et al. [3] studied online patient education and risk assessment in inherited breast cancer. Many people are concerned about their family history of breast cancer, and are anxious about the possibility of developing breast cancer themselves. The majority of these people are likely not to be at significantly increased risk of developing inherited breast cancer. All women are at risk of developing sporadic breast cancer, and this risk increases with age. This project aims to promote people's understanding of these issues using an interactive online computer programme. Based upon guidelines from the UK National Institute of Health and Clinical Excellence the authors developed a user-friendly computer programme named OPERA (Online Patient Education and Risk Assessment) which captures the individuality of the user's situation in a comprehensive way, and then produces personalised information packages, building on the theoretical framework of argumentation developed by Stephen Toulmin.

The European definition of General Practice states that GPs should use professional competence in their communication with patients. Their communication skills are particularly challenged in the field of lifestyle improvements. Starting from the observation that most GPs feel they lack efficacy in achieving lifestyle changes, the study by Thijs [4] describes the

development of a program to train GPs in communication skills to achieve lifestyle improvements. A literature search was conducted to build an inventory of models that could be used to train GPs. Experts on specific methods and topics were consulted to get acquainted with their specific approaches. Experts in the field of CME were gathered to discuss barriers and solutions to overcome these barriers. During steering group meetings, several possible solutions were discussed aiming at facilitating behaviour changes in the following areas: stop smoking, decrease alcohol consumption, eat healthy food, and increase physical activity. The authors' guidelines recommend brief motivational interviews for health behaviour changes. The authors' experience shows that the developed Trans Theoretical Model and the brief motivational interviewing approach are accepted by health care, educational, and scientific organisations. The process of integrating this approach into GPs' daily practice has to be continued and needs better evaluation in the long run.

3. Cultural factors

Larkey and Gonzalez [5] compared a culturally aligned, brief storytelling educational intervention (ST) to a numeric risk tool intervention (NR) using the Harvard Cancer Risk Index to promote colorectal cancer (CRC) prevention and early detection among Latinos. Both interventions included risk factual information and recommendations for primary prevention and screening for CRC. Sixty-four Latinos (mean age 46.8, 86% female) were randomised and completed pre- and post-tests. Participants in story telling indicated intent to add significantly more servings of vegetables and more minutes of exercise to daily routines than those in NR. Most respondents (ST and NR) reported intentions to recommend CRC screening to friends and relatives. These data should encourage caregivers to develop creative solutions for patient populations that are difficult to reach with standard information tools. Storytelling shows promise as an effective method for reaching one of the historically underserved ethnic groups with cancer prevention and screening information.

Dieterich [6] studied *The modern patient: a threat or promise?* The study focuses on physicians' ideas of their patients' attributes and examines how the German medical community employs the currently popular idea of the modern patient. The official publication of the German medical community, the weekly journal "Deutsches Ärzteblatt", was searched for articles addressing the topic of the modern patient during the 10-year period 1996–2005. A total of 73 articles were analysed using qualitative research methods and from the perspective of discourse analysis. Assessments of 'the modern patient' are heterogeneous. There are four definable discursive clusters: 'Law and Ethics', 'Knowledge and Information', 'Structural Health Care Problems' and 'Funding Issues'. Attributes currently ascribed to patients fit into broader modernisation processes of health care systems. This involves new opportunities for patients' empowerment as well as new forms of involvement and the burden of self-reliance. Reflecting on the complexity of physicians' views of patients

'desirable' attributes within a particular physician–patient interaction, helps to assess the physician's expectations of the patient, e.g. prevailing ideas on autonomy or responsibility, including the question, when these concepts are in the best interest of an individual patient.

A way to solve cultural gaps in the doctor–patient communication is the use of interpreters. Rosenberg et al. [7] studied Physician perceptions of professional and family interpreters, on their performance of doctor–communication tasks, as described in the Calgary–Cambridge Framework. Physician ($N = 19$) encounters with patients ($n = 24$) accompanied by an interpreter were videotaped. Stimulated recall was used to elicit participants' perceptions of the clinical encounter. The authors analysed transcriptions of the physician interviews using Atlas-ti software. Physicians perceived all communication tasks to be more difficult using an interpreter than when one was not needed. Physicians perceived family interpreters to be less skilled translators than professional interpreters. Physicians expected professional interpreters to serve as 'culture brokers' as well. Family interpreters were automatically addressed as if they were in the role of a caregiver, even though only some did have this function. With professional interpreters, physicians follow professional communication rules. In contrast, physicians act as though these rules are not relevant with family interpreters whom they treat as caregivers.

A classical topic in communication research is the patient's (mis-) interpretation of prescription drug label instructions. Wolf et al. [8] examined the nature and cause of patients' misunderstanding of common dosage instructions on drug container labels. Interviews including a literacy assessment were conducted among 395 patients at one of three primary care clinics. Patients were asked to read and demonstrate understanding of dosage instructions for five common prescription medications. Correct understanding was determined by a panel of blinded physician raters reviewing patient verbatim responses. Qualitative methods were employed to code incorrect responses and generate themes regarding causes for misunderstanding. Rates of misunderstanding for the five dosage instructions ranged from 8% to 33%. Patients with low literacy had higher rates of misunderstanding compared to those with marginal or adequate literacy. The incorrect responses were qualitatively reviewed yielding six common causes for misunderstanding: label language, complexity of instructions, implicit vs. explicit dosage intervals, presence of distractors, label familiarity, and attentiveness to label instructions. It turned out that the instructions are often awkwardly phrased, vague, and unnecessarily difficult. Prescription drug labels should use explicit dosing intervals, clear and simple language, within a patient-friendly label format.

4. Qualitative approaches

Two studies explicitly applied qualitative approaches. Röing et al. [9] used a phenomenological approach to describe patients with oral cancer. The aim of this retrospective qualitative study was to describe how patients with oral cancer experience their sickness and treatment. A small purposeful sample of seven

patients with oral cancer was interviewed. Data were analysed using a phenomenological approach outlined by Van Manen. The essence of patients' experiences can be described as an 'embodiment' in the mouth that has become unreal, or 'uncanny'. At the beginning of treatment patients describe their body as being invaded by cancer, during treatment they cannot get rid of their wounded mouth, at treatment end the mouth is disabled. Findings indicate that oral cancer patients' need for support may increase as treatment progresses and may be greatest at the end of radiotherapy, as they return home with mouths that have not recovered after treatment and do not function normally. This suggests first the importance of understanding the unique situation of patients during treatment and second the chance to provide help on their way to regain normal mouth function at the end of treatment. If possible, plans for oral rehabilitation should be considered already during initial treatment planning.

Karnieli-Miller [10] studied dilemmas in the (un)veiling of the diagnosis of Alzheimer's disease by using qualitative and phenomenological approaches by combining pre-encounter interviews with physicians, observations of actual encounters of diagnosis disclosure of AD, and post encounter interviews. The aim was to enhance the understanding and effect of physician's difficulties, attitudes and communication styles on the disclosure of the diagnosis of AD in practice. There were various ways or tactics to (un)veil the bad news that may be perceived as different ways of dulling the impact and avoiding full and therefore problematic statements. In the actual encounters this was accomplished by keeping encounters short, avoiding elaboration and confirmation of comprehension and explicit terminology, and by using fractured sentences. The present study's findings highlight the difficulties encountered in breaking the news about AD, in the way it is actually done, and the problems that may arise from this way of un/veiling the news. The main problem is that the reluctance to make a candid disclosure of the diagnosis as was demonstrated in this study may violate basic moral and legal rights and may also deprive patients and caregivers of some of the benefits of early disclosure of diagnosis. There is a need for assisting physicians to cope with their personal difficulties, problems and pitfalls in breaking the news.

5. Nonverbal behaviour and beyond

In an invited lecture on non-verbal behaviour Schmid Mast et al. [11] stressed the importance of nonverbal communication in the physician-patient interaction. Interpersonal judgment relies mostly on nonverbal signals and cues in the appearance of the social interaction partner. This is also true for the physician-patient interaction. Moreover, physicians and patients sometimes tend to mirror and sometimes to complement each other on certain aspects of their nonverbal behaviour. Nonverbal cues emitted by the patient can contain important information for the doctor to use for treatment and diagnostic decisions. The way the physician behaves nonverbally affects patient outcomes, such as, for instance, patient satisfaction. Affiliative nonverbal behaviour (e.g. eye gaze, proximity) of the physician is related to higher

patient satisfaction. However, how aspects of physicians' nonverbal behaviours are related to patient satisfaction, also depends on personal attributes of the physician such as gender. Physician training could profit from incorporating knowledge about physician and patient nonverbal behaviour.

Langewitz [12] went one step beyond non-verbal behaviour in his invited lecture on: Beyond content analysis and non-verbal behaviour—what about atmosphere? He summarised basic assumptions underlying empirical research in patient-caregiver communication as: good communication will be better understood and easier to teach when its single constituents are identified. The paper points to the limitation of this approach. Based upon the terminology of phenomenological thinking grounded in Neo-Phenomenology (Hermann Schmitz) contradictory findings from the literature on patient-centred communication in internal medicine and oncology are used as a starting point to elucidate different paradigms in conducting research in clinical communication. The phenomenological approach of Hermann Schmitz that he uses in his paper is based upon experiences that 'on the average everybody can vividly access or retrieve from his memory'. The inclusion of the phenomenon of a certain atmosphere during an encounter is recommended referring to the impression of 'something in the air' that can be identified during communication or upon entering a room. Even though it can be sensed with high evidence, it cannot be deduced from particular observations. Instead, the atmosphere is part of a situation in which meaning is dissolved in chaotic manifoldness. Sensing an atmosphere is a function of the lived body (Leib) as opposed to phenomena that are mediated by the senses. How research and education might profit from the application of these concepts is briefly outlined. Including perceptions of the lived body (Leib) should improve research in clinical communication and the design of teaching courses.

6. Classical patient provider studies

Loh et al. [13] investigated: The effects of a shared decision making intervention in primary care of patients with depression. The study assessed, whether enhanced patient participation in decision-making leads to improved treatment adherence, satisfaction, and clinical outcome without increasing consultation time. A cluster-randomised controlled intervention study was based on physician training plus patient-centred decision aid compared to usual care in primary care settings in Germany. Twenty-three primary care physicians treating 405 patients with newly diagnosed depression were included. Physician facilitation of patient participation improved significantly and to a greater extent in the intervention compared to the control group. There was no intervention effect for a reduction of the severity of depression. Doctor facilitation of patient participation, patient-rated involvement, and physician assessment of adherence improved only in the intervention group. Patient satisfaction at post-intervention was higher in the intervention group compared to the control group. The consultation time did not differ between groups. Additional research is needed to model causal linkages in the decision-making process with regard to outcomes. The study results encourage the

implementation of patient participation in primary care of depression.

Makoul et al. [14] measured patient views of physician communication skills, an application of the Communication Assessment Tool (CAT). They developed and tested a tool that can be used by patients to assess the interpersonal and communication skills of physicians across clinical specialties. The study began by developing a psychometrically sound CAT. This process yielded a 15-item instrument that is written at the fourth grade reading level and employs a five-point response scale, with 5 = excellent. Fourteen items focus on the physician and one targets the physician's staff. A field test with 38 physicians and 950 patients (25 patients per physician) yielded an average patient-reported mean score per physician of 4.68 across all CAT items (S.D. = 0.54). The average proportion of excellent scores was 76.3% (S.D. = 11.1). The CAT is a reliable and valid instrument for measuring patient perceptions of physician performance in the area of interpersonal and communication skills. The field test demonstrated that the CAT can be successfully completed by both physicians and patients. Reporting the proportion of "excellent" ratings given by patients is more useful than summarizing scores via means, which are highly skewed. Specialty boards, residency programs, medical schools, and practice plans may find the CAT valuable for both collecting information and providing feedback about interpersonal and communication skills.

Weber et al. [15] provide data on a largely neglected field in clinical communication: They describe the content and mode of patient–physician–nurse interactions during ward-rounds in internal medicine. In 267/448 patients, 13 nurses, and 8 physicians from two wards in general internal medicine 448 interactions on ward rounds were tape recorded by observers. After exclusion of interactions with more than three participants ($N = 150$), a random sample of 90 interactions was drawn. Data were analysed with a modified RIAS version that allowed for the registration of a third contributor and for the assessment of the direction of a communicative actions. Furthermore, time spent per individual patient was registered. A total of 10,713 utterances (151 per ward round interaction) were analysed. The average time allotted to an individual patient during ward-rounds was 7.5 min (range 3–16 min). The exchange of medical information was the most prominent topic in physicians (39%) and nurses (25%), and second common topic in patients (28%), in whom communicative actions like agreement or checking are more common (30% patients/25% physicians/22% nurses). Patients receive about 20 bits of medical or therapeutic information per contact during ward-rounds. Analysing the contribution of nurses' shows that their knowledge is under-represented. Patients receive so much information per interaction with a physician that it remains unclear what they will ever keep in mind. Further research should try to determine whether the quality of patient care is related to a better balanced exchange of information, to which nurses, physicians, and patients contribute their specific knowledge. Instead of increasing the number of information items per ward round interaction, an intelligent selection process must be developed to tell the individual patient only what she or he needs and wants to know.

7. Conclusions

This issue gives an impression of the most central topics that are dealt with in communication in health care, reaching from basic empirical research using quantitative (e.g. Loh et al. [13]) and well founded qualitative methods (e.g. Karnieli-Miller et al. [10] and Röing et al. [9]) to more general reflections about the short-comings of current research paradigms and the additional value phenomenological approaches might offer as presented by Langewitz [12].

Some papers investigate different means of providing information reaching from highly sophisticated web-based solutions (e.g. Mackay et al. [3]), (mis-)understanding of written drug label instructions by Wolf et al. [8] to story telling in a Latino patient population by Larkey and Gonzalez [5].

Other authors focus on situations when it is especially difficult to reach common ground: in patients with multiple unexplained symptoms where GPs find it especially difficult to develop shared explanatory models by Salmon [1] to triadic interactions with the inclusion of an interpreter by Rosenberg et al. [7]. Ways to facilitate changes in behaviour or attitudes are investigated in patients with AIDS and depression by Coppola [2] and Loh et al. [13], and in physicians by Thijs [4]. The sources of images physicians have of the 'modern patient' are described in the paper by Dieterich [6], the assessment of the ways patients perceive their physicians is the focus of the paper by Makoul et al. [14]. Schmid Mast [11] summarises findings on non-verbal aspects of communication, and Weber et al. [15] present data on a largely neglected field in clinical communication research: patient–physician–nurse interactions during ward rounds in hospital.

This issue of PEC demonstrates how thoroughly researchers within the networks of EACH and AACH (the American Association for Communication in Health Care) investigate various aspects of communication in health care. We are looking forward to the next events in the series of conferences on this topic, organised by AACH in Charleston (USA), October 9–12, 2007, and to the next conference organised by EACH in Oslo (NOR), September 2–5, 2008.

References

- [1] Salmon P. Conflict, collusion or collaboration in consultations about medically unexplained symptoms: the need for a curriculum of medial explanation. *Patient Educ Couns* 2007;67:246–54.
- [2] Coppola MV. Preventing without stigmatizing: the complex stakes of information on AIDS. *Patient Educ Couns* 2007;67:255–60.
- [3] Mackay J, Schulz P, Rubinel S, Pithers A. Online patient education and risk assessment project OPERA from cancer backup putting inherited breast cancer risk information into context using argumentation theory. *Patient Educ Couns* 2007;67:261–6.
- [4] Thijs G. GP's consult and health behaviour change project. Developing a program to train GPs in communication skills to achieve lifestyle improvements. *Patient Educ Couns* 2007;67:267–71.
- [5] Larkey LK, Gonzalez J. Storytelling or promoting colorectal cancer prevention and early detection among Latinos. *Patient Educ Couns* 2007; 67:272–8.
- [6] Dieterich A. The modern patient-threat or promise? Physicians' perspectives on patients' changing attributes. *Patient Educ Couns* 2007;67:279–85.

- [7] Rosenberg E, Leanza Y, Sellar R. Doctor–patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. *Patient Educ Couns* 2007;67:286–92.
- [8] Wolf MS, Davis TC, Shrank W, Rapp D, Connor U, Bass PF, Clayman M, Parker RM. To err is human: patient misinterpretations of prescriptions drug label instructions. *Patient Educ Couns* 2007;67:293–300.
- [9] Roing MM, Hirsel JM, Hölstrom I. The uncanny mouth: a phenomenological approach to oral cancer. *Patient Educ Couns* 2007;67:301–6.
- [10] Karnieli-Miller O, Werner P, Ahron-Peretz, Eidelman S. Dilemmas in the (un)veiling of the diagnosis of Alzheimer’s disease: walking an ethical and professional tight rope. *Patient Educ Couns* 2007;67:307–14.
- [11] Schmid Mast M. On the importance of non-verbal communication in the physician–patient interaction. *Patient Educ Couns* 2007;67:315–8.
- [12] Langewitz WA. Beyond content analysis and non-verbal behaviour—what about atmosphere? A phenomenological approach. *Patient Educ Couns* 2007;67:319–23.
- [13] Loh A, Simon D, Wills C, Kriston L, Niebling W, Harter M. The effects of shared decision making intervention in primary care of depression: a cluster-randomized trial. *Patient Educ Couns* 2007;67:324–32.
- [14] Makoul G, Krupat E, Chih-Hung Chan. Measuring patient views of physician communication skills: development and testing of the communication assessment tool. *Patient Educ Couns* 2007;67:333–42.
- [15] Weber H, Stöckli M, Nübling M, Langewitz WA. Communication during ward rounds in internal medicine; an analysis of patient–nurse–physician interactions using RIAS. *Patient Educ Couns* 2007;67:343–8.

President

Wolf Langewitz*

EACH, Basle, Switzerland

Special Issue Editor

Adriaan Visser

Patient Education and Counseling,

Rotterdam, the Netherlands

*Corresponding author

E-mail address: wlangewitz@uhbs.ch

Author's personal copy