Supporting the Development of Patient-Centred Communication Skills

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Abstract

This chapter critically appraises the main pedagogic approaches used to support the development of patient-centred clinical communication. It begins by tracing the emergence of patient-centredness as a relational model in healthcare and reviews a range of perspectives of what the term has come to mean. The rationale and evidence base for adopting patient-centred communicative practice as core to its delivery are examined, including its role in enhancing clinical outcomes and relationships to provide high quality, humane care. Methods for supporting learners' development of communication through simulated and workplace learning are considered, with reference to the educational theories of behaviourism, experiential learning, and social constructivism. These methods are critically evaluated in respect of their strengths and limitations in promoting the skills

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and ethos of patient-centred communication. Critiques of the transfer model of learning are highlighted, as is the dissonance students experience between simulated and authentic communicative practice. Barriers to the development and sustainment of a patient-centred approach in the clinical environment are considered and interventions informed by research studies and workplace learning theories are proposed to help mitigate these. The pivotal role of patients in helping learners to appreciate and develop patient-centred attitudes and skills, through formal involvement in healthcare education as well as clinically based encounters, is discussed. Finally, additional online resources which can be used to further support patient-centred learning are signposted.

Keywords

Clinical communication · Communication skills · Patient-centredness · Pedagogy

Introduction

The centrality of patient-centredness, allied with skilled communication, for the delivery of high-quality healthcare is well recognized (Pawlikowska et al. 2012; Mead and Bower 2002). Attempts to capture its meaning have yielded a range of definitions (Mead and Bower 2000; Stewart et al. 2006; Brown et al. 1986). Core to these constructs is placing patients' needs, and what is important from their perspective, at the forefront of clinical endeavors. The argument for this approach has been made from a number of standpoints, including its role in enhanced clinical outcomes, increased patient satisfaction, and as a moral imperative in the provision of healthcare (Duggan et al. 2006; Stewart 1995; Mead et al. 2002). Delivering patient-centred care is, however, not without its challenges. These range from macro-level system and organizational barriers (Hower et al. 2019) through to micro interactional level factors (Maynard and Heritage 2005). The need for organisational and governance structures which support such practice is reflected in policy documents internationally (ACSQHC 2010; DoH 2012), and their implementation can be considered a prerequisite to achieving and sustaining its delivery. While acknowledging the impact of the wider systemic healthcare context, the focus of this chapter lies in the interactional domain of clinical care and how patient-centred communicative practice can be developed and supported.

Part 1 of this chapter provides the context from which patient-centred practice and communication have emerged. It does so by tracing the origins of patient-centredness as a relational model in healthcare, with consideration of its key features and its inter-relationship with clinical communication. It also discusses the rationale for why this approach has been widely adopted in modern healthcare systems. Part 2 of the chapter focuses on the development of patient-centred communication through a range of teaching and learning modalities, with reference to relevant educational theory. It examines the strengths and limitations of the pedagogic

methods employed in this field and how the patient's voice can be embedded within training and education programs.

Part 1: Patient-Centredness: Origins, Definitions, and Relation to Clinical Communication

The Emergence of Patient-Centredness as a Relational Model in Healthcare

The dynamics of physician-patient relations have been documented since antiquity and should be viewed within the prevailing socio-political and intellectual-scientific contexts of the time (Kaba and Sooriakumaran 2007). Drawing on historians' accounts of medical practice in eighteenth and nineteenth-century Western Europe, we can trace the shifting power balance between practitioners and patients (Jewson 1976; Porter 1997). During this era, medical practitioners, unlicensed and unregulated, plied their trade among the elite classes who had the means to afford their ministrations. Their relationship was marked by a degree of reciprocal regard. The patients selected practitioners for their personal and "healing" qualities, whilst practitioners, wanting to satisfy their patrons' wishes, displayed a personalized interest and concern. The patients' subjective experience of illness was paramount and, in the absence of scientific clinical data, formed the basis for diagnosis and treatment. However, this approach changed radically with the emergence of scientism and the resultant paradigmatic shift to biomedicine as the dominant medical model. The confinement of patients to the newly established hospitals facilitated their "objective" medical assessment using novel diagnostic tools and laboratory techniques. This regime, termed the "medical gaze" by Foucault (1976), saw the separation of the patient's bodily pathology from that of their subjective personhood and negated the previous reliance on their illness narrative to achieve diagnosis. The concurrent professionalization of medical practice further legitimized the doctor's role as "expert" on the patient's condition and arbiter of treatment regimens, based on scientific data rather than subjective experience. This transfer of control to the doctor, now deemed to be acting in the perceived "best interest" of a compliant patient, heralded a new, paternalistic model of care which remained dominant until the late twentieth century (Szasz and Hollender 1956).

By the mid-1900s, the hegemony of the medical model was subject to increasing critique (Friedson 1970) and in the 1960s the term "patient-centredness" entered the medical lexicon. This terminology reflected a realigning of the power dynamic in the patients' favor. It included the reinstatement and primacy of the patients' perspective in the clinical encounter and the adoption of "whole-person medicine" (Balint 1969). This thinking was further advanced by Stewart et al. (2006) who advocated for a "transformed clinical method" espousing the holism of a biopsychosocial perspective, intended to counter the reductive tendencies of the biomedical model. Continuing support for patient-centred practice has led to its endorsement by influential international organizations (ACSQHC 2010; DoH 2012) as central to high-quality

healthcare (Epstein and Street 2011), resulting in its adoption as the prevailing model of health service delivery in the twenty-first century.

Defining Patient-Centredness

Despite the increasing espousal of patient-centredness as a model of healthcare, a universal definition of the term remains elusive, perhaps not surprisingly given its scope from conceptual model through to the domains of policy and practice. Illingworth's (2016) review illustrates the range of characterizations attributed to the term through the following three examples.

The first is the UK Department of Health's (DOH 2004) reference to patient-centredness as a "philosophy of care" that encourages:

(a) *A focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts, and/or*
(b) *Shared control of the consultation, decisions about interventions or management of health problems with the patient*

Of note here, and supported by recent health policy guidance (DoH 2012), is the explicit recognition of shared decision-making as central to an egalitarian clinician-patient contract.

The second example is Mead and Bower's (2000) commonly cited conceptual framework which identifies the following five dimensions of patient-centredness:

- Biopsychosocial perspective (including social, psychological, and biomedical factors)
- Patient as person (understanding the personal meaning of the illness)
- Sharing power and responsibility (responding to patient's preferences for information and shared decision-making)
- Therapeutic alliance (developing common therapeutic goals and enhancing the personal bond between doctor and patient)
- Doctor as person (recognizing the influence of personal qualities and subjectivity on medical practice)

This model emphasizes the intersubjective nature of clinical relationships and how these facets may influence the process and outcomes of clinical care.

The final example is Scholl et al.'s (2014) systematic literature review and concept analysis, from which they identify 15 dimensions of patient-centredness, grouped under three themes: Principles, Enablers, and Activities, as set out in Fig. 1.

Scholl's encompassing overview illustrates how original notions of patient-centredness (focusing on individual circumstances, values, and needs) have evolved into an increasingly multidimensional concept. It has expanded beyond the doctor-patient relationship to include important "others," be that family members, carers, or the wider health/social care team. It may also incorporate how services are structured

	Brief description
PRINCIPLES	
Essential characteristics of the clinician	A set of attitudes towards the patient (e.g. empathy, respect, honesty) and oneself (self-reflectiveness) as well as medical competency
Clinician-patient relationship	A partnership with the patient that is characterized by trust and caring
Patient as unique person	Recognition of each patient's uniqueness (individual needs, preferences, values, feelings, beliefs, concerns and ideas, and expectations)
Biopsychosocial perspective	Recognition of the patient as a whole person in his or her biological, psychological, and social context
ENABLERS	
Clinician-patient communication	A set of verbal and nonverbal communication skills
Integration of medical and non-medical care	Recognition and integration of non-medical aspects of care (e.g. patient support services) into health care services
Teamwork	Recognition of the importance of effective teams characterized by a set of qualities (e.g. respect, trust, shared responsibilities, values, and visions) and facilitation of the development of such teams
Access to care	Facilitation of timely access to healthcare that is tailored to the patient (e.g. decentralized services)
Coordination and continuity of care	Facilitation of healthcare that is well coordinated (e.g. regarding follow-up arrangements) and allows continuity (e.g. a well-working transition of care from inpatient to outpatient)
ACTIVITIES	
Patient information	Provision of tailored information while taking into account the patient's information needs and preferences
Patient involvement in care	Active involvement of and collaboration with the patient regarding decisions related to the patient's health while taking into account the patient's preference for involvement
Involvement of family and friends	Active involvement of and support for the patient's relatives and friends to the degree that the patient prefers
Patient empowerment	Recognition and active support of the patient's ability and responsibility to self-manage his or her disease
Physical support	A set of behaviour that ensures physical support for the patient (e.g. pain management, assistance with daily living needs)
Emotional support	Recognition of the patient's emotional state and a set of behaviour that ensures emotional support for the patient

Fig. 1 "Dimensions of Patient-Centeredness". (Reproduced courtesy of Scholl 2014©) Scholl et al. (2014)

and delivered to support patient-centred care and include promoting patients' autonomy and self-management capacities.

Clinical Communication and Patient-Centredness

The relationship between clinical communication and patient-centredness has been characterized in a number of ways. Byrne and Long's (1976) seminal study of doctors' audio-recorded General Practice consultations illuminated the impact of their communication style on the extent to which patients were able to actively participate in the consultation, a core requisite of patient-centred practice. The following decade, Mishler (1984) examined medical consultations using a discourse analytic approach. He described how the dynamic of the "voice of the lifeworld" (patients' personal accounts of their illness) and the "voice of medicine" (the doctor's focus on the disease) manifested in the interactions. In doing so he identified communicative acts on the part of the doctor which either facilitated or blocked discussion of "lifeworld" issues. He concluded that interactions dominated by the "voice of medicine" resulted in less humane and less effective patient care.

The findings from such studies have subsequently been used to inform the development of patient-centred consultation models and frameworks. For example, McWhinney's (1989) Disease-Illness Model illustrates the differing agendas of the doctor (with a focus on signs, symptoms, investigations, differential diagnosis) and of the patient (with a focus on ideas, concerns, expectations, and personal experience). The model outlines the doctor's role in integrating these agendas to arrive at a mutual understanding of the patient's problem and enable shared decision-making regarding its management. The Calgary-Cambridge Guide (Kurtz et al. 2003) provides a framework for conducting a patient-centred consultation so that eliciting the patient's perspective and shared decision-making are incorporated in the process. It also identifies a range of evidence-based verbal and non-verbal communication skills which can be drawn upon to build the clinician-patient relationship and achieve the aims of the consultation.

Evidence and Justification for Patient-Centred Clinical Practice and Communication

Studies attempting to provide a clear evidential basis for patient-centred care are hampered by the varied (or lacking) definitions of the concept, thereby undermining their validity and comparability (Illingworth 2016). Rathert et al.'s (2012) systematic review of the literature pertaining to outcomes illustrates this perfectly, with some studies reporting a direct correlation between aspects of patient-centred care and improved outcomes, while others found no clear relationship. Overall, the evidence for greater patient satisfaction and improved self-management was stronger than for other clinical outcomes. Methods for researching the process and effects of clinical communication continue to develop (Roter and Larson 2002; Krupat et al. 2006). A number of studies have reported on health outcomes relating specifically to patient-centred communication. For example, Stewart (1995) reported positive correlations in sixteen studies, such as improvements in patients' emotional health, symptom resolution, and physiologic measures (including blood pressure, glycaemic and pain

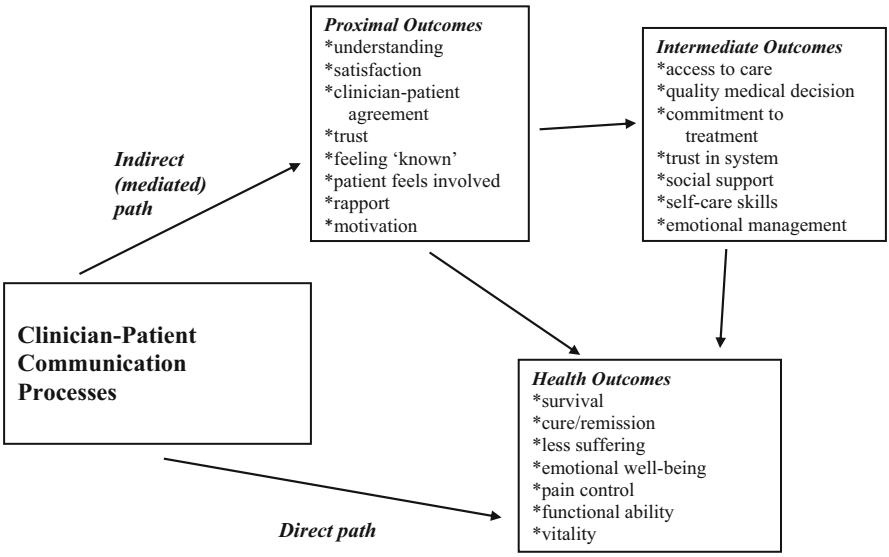

Fig. 2 "Communication pathways to improved health outcomes" (Reproduced from Street 2013). (Reproduced with permission of Elsevier©)

control). However, Street (2013), recognizing the challenge of identifying direct correlations advocates a more nuanced approach. This involves modeling the pathways that capture both direct and indirect effects that communication may have on patient welfare (Fig. 2). This involves investigating the influence of communication on intervening variables which may lead to improved outcomes. For example, the development of trust in the doctor-patient relationship may increase patient engagement with health services, which in turn enables positive outcomes.

So, despite some inconclusive investigations, a substantial body of research evidence has been amassed to support patient-centred communication as beneficial for both enhanced clinical outcomes and increased patient satisfaction.

In addition to the evidence base outlined above, the case for patient-centredness as a moral imperative in healthcare delivery has also been made. Duggan et al. (2006) draw on the following theoretic frameworks to support this argument:

(i) Consequentialist moral theories – focusing on the positive outcomes of providing patient-centred care.
(ii) Deontological theories – emphasizing how patient-centred care reflects the ethical norms of medicine, such as respect for persons and shared decision-making.
(iii) Virtue-based theories – highlighting the importance of developing patient-centred attitudes and traits, which influence the ways clinicians behave toward their patients.

The authors emphasize the value of these frameworks in legitimizing patient-centredness as a morally valuable concept for clinical practice.

In conclusion, patient-centred communication and practice are evidentially well-supported for their benefits to both clinical outcomes and patient experience. Greater precision, in terms of which definitions of patient-centredness (or its domains) are being used, would enhance future studies. Also, further consideration should be given to the impact of mediating communication variables on health outcomes and how these can be captured. The moral argument for valuing and respecting all those within the healthcare domain as "the right thing to do" has also been posited, along with the empiric justification for patient-centred practice.

Part 2: Supporting the Development of Patient-Centred Communication – Approaches to Teaching and Learning

The history of clinical communication in the practice of medicine, as previously outlined, provides the context from which it has come to be recognized as a discrete discipline in healthcare education. This includes the evolving political and societal backdrop, policy developments, and growing evidence-base relating to improved outcomes resulting from effective, patient-centred communicative practice (Stewart et al. 2006; Brown 2008). In contrast to the previous apprenticeship style of learning in the clinical milieu, involving diverse role modeling and a degree of trial and error, clinical communication is now widely established as a formal and requisite component of healthcare training programs (Bachmann et al. 2013; Noble et al. 2018). Research evidence suggests longitudinal, helical curriculum structures as most effective in supporting learners' development in this area, rather than concentrated or truncated learning episodes (van Dalen et al. 2002). Post-graduate courses of at least one-day duration have also been found to effect positive changes, though this is contingent on training being learner-centred and with a focus on active skills practice (Berkhof et al. 2011).

The following sections review the predominant methods employed in clinical communication teaching and learning, under the broad headings of clinical simulation and work-based learning. These will be discussed with reference to relevant educational theories including behaviourism, experiential learning, and social constructivism, with consideration of how these approaches contribute to the development of patient-centred practice.

Clinical Simulation

Clinical simulation is a commonly used method for the development of communication skills (Hargie et al. 2010), providing learners with the opportunity to conduct consultations with simulated patients (trained actors). It allows students to receive feedback from the patients' perspective, as well as from their peers and tutor. Simulations may be recorded enabling subsequent review and analysis of the

interactions. This pedagogic method is primarily informed by behaviourist and experiential learning theories, which will be briefly outlined, before considering their role in developing patient-centred communication.

Simulation and Behaviourism

Behaviourist learning principles have been widely adopted in medical education including clinical communication teaching. Developed by psychologists during the twentieth century (Skinner 1954), the approach aims to bring about behavioural changes in the learner to meet specified standards or competencies. It assumes that "...physical actions such as thinking, acting and feeling can be regarded as behaviours in a teaching and learning setting" (Brown 2016a, p.181) thereby being observable, and for assessment purposes, measurable. When applied to clinical skills teaching this approach centres on breaking down complex tasks into component parts. These can be repeatedly practiced and refined with the aid of feedback. Behaviourist principles continue to inform clinical communication pedagogy. This is illustrated, for example, in the way the Calgary-Cambridge Guide is used for instructional purposes (Hargie et al. 2010; Kurtz et al. 2003). The framework allows for the deconstruction of the consultation into its component phases (opening, gathering information, etc.) and constituent skills (e.g., listening, question styles), which can be honed with the aid of observation and feedback.

Simulation and Experiential Learning

The use of simulation is also informed by experiential learning theory, defined as "... a teaching philosophy that informs many methodologies in which educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop people's capacity to contribute to their communities" (AfEE 2020). Experiential learning sits within a social constructivist paradigm which supports the exploration of how learners understand and construct their views of the world, facilitated through critical reflective practice. As such the role of the teacher becomes that of a facilitator rather than an instructor, whose purpose is to support learners' engagement with, and reflection on, suitable experiences. The case for simulation is supported by recognition that experiential methods are more effective than didactic instruction for clinical communication teaching and learning (Aspegren 1999; Lane and Rollnick 2007).

Critical Considerations of Simulation for Developing Patient-Centred Communication

Behaviourism, Skills Development, and Patient-Centredness

While there is evidence that experiential learning in the form of clinical simulation is effective for developing communication skills, how confident can we be that this method helps to promote *patient-centred* communication? We can begin by considering the effect of the behaviourally informed skills approach. This involves mastering of a range of skills intended to convey interest and respect, facilitate patient

involvement and elicit a biopsychosocial understanding of the patient's circumstance. Attainment of these skills through rehearsal, receipt of feedback and reinforcement, may indeed be viewed as a positive leaning outcome, at least in equipping trainees to conduct a patient-centred consultation. However, this approach has been questioned for its role in promoting a restrictive discourse and practice of "communication skills," at the expense of a more encompassing and creative appreciation of "clinical communication" as a subject (Skelton 2008; Salmon and Young 2005). For example, in seeking to demonstrate specified skills such as empathic responses or open questions, there is a risk of developing mechanistic or superficial techniques, to the detriment of genuine responsiveness and engagement with patients. At its extreme, a focus solely on observable and demonstrable communicative acts, without reference to underlying principles and values, may be viewed as a mere training in de-contextualized surface skills (Hanna and Fins 2006). The counter argument is that through deploying patient-centred communication skills learners may come to recognize their effects and benefits, thereby fostering patient-centred attitudes. This is a contention which warrants further focused research (Fernández-Olano et al. 2008). In practice the majority of curricula whilst employing skills-based methods, integrate allied subject areas such as professionalism and medical ethics, and in some instances medical humanities, to promote a rounded consideration of clinical communication. The extent of such integration, however, varies considerably between programs (Hargie et al. 2010; Noble et al. 2018).

A further concern regarding a skills-based approach is that it assumes a transfer model of learning, whereby skills mastered in one context are deemed transferable to another (Brown 2016a). For example, patient-centred communication skills honed in a controlled classroom environment may prove challenging to apply in practice, given the cultural vagaries of the actual clinical setting. The powerful "informal" influence of real-life role modeling and practices, known as the hidden curriculum, is well recognized in undermining the ideals students are encouraged to adopt in formal curricula (Hojat et al. 2009; Hafferty 1998). Bombeke et al. (2012) also identified tiredness and time pressures as detrimental to the transfer of communication skills training to the clinical setting. Despite this, they reported that medical students and junior doctors continued to apply skills learned in training to everyday practice and found them of particular help in challenging situations. The authors concluded that while "best-evidence skills training" remains important, learners need support to incorporate such skills creatively into their personal communication styles. This reflects the notion of "genuineness" as a core attribute of relationship-centred care (Beach and Inui 2006) and its role in countering a mechanistic application of learned communication skills.

Experiential, Simulated Learning, and Patient-Centredness

Though experiential learning theory is relevant to both practice-based and simulated learning, it is considered here in relation to the latter. As previously noted, simulation is commonly used in communication curricula (Hargie et al. 2010) and has a number of advantages. It provides an environment in which learners can prepare to undertake

"real-life" consultations without risking harm to patients and with the opportunity to focus in depth on the interactive/relational process rather than medical management. It is also a means to strategically deliver key learning material (Hanna and Fins 2006). Though widely used and recognized as pedagogically effective for skills development, the limitations of simulation for instilling patient-centred attitudes are also recognized.

Yardley et al. (2013) conducted a study of medical students' experiences of simulated and authentic patient interactions. It revealed that students identify a dissonance, or "gap," in their learning between these two spheres. For example, students described feelings of responsibility towards real patients which were lacking in simulated encounters, and of feeling less "judged" in their practice-based interactions than in the performative context of simulation. They also perceived differences between how actual and simulated patients responded, associating the latter with delivering the learning agenda of clinical communication faculty. The authors argue that this dissonance requires recognition and attention if students are to maximize learning from both environments. Rather than viewing the metaphorical gap as a negative source of disconnection, Yardley et al. draw on Vykostsky's (1978) social constructivist approach to reframe it as a valuable opportunity for extending learning, i.e., as a "zone of proximal development." For this to be effective students require support to reflect on and assimilate learning from both contexts, in order to:

(a) Facilitate their active construction of patient-centred communication and practice
(b) Resolve tensions between simulated practice and that witnessed and experienced in the workplace

Hanna and Fins (2006) caution that an over-reliance on simulation, as a proxy for real-life patient engagement, may result in clinicians who are able to ". . .act out a good relationship with their patients but have no authentic connection with them" (p.265). To counter this potentiality they recommend that simulated learning should be coupled with early clinical exposure, whereby students can experience the communicative challenges of clinical practice first-hand. This, they argue, will promote the relevance of simulated learning in preparing for real-life situations and motivate students to consider their personal and professional responses to these encounters. This view resonates with relational models that highlight the importance of the clinician "as person," cognisant of their values in the context of patient relationships (Mead and Bower 2000).

So far, we have considered simulation as a core pedagogic method for the development of clinical communication through the educational lenses of behaviourism, experiential learning, and social constructivism. We have also considered the strengths and limitations of these approaches in helping to promote patient-centred communicative practice. What emerges is confirmation that skills-based teaching and learning, delivered through credible simulations, is effective for equipping learners with strategies for use in clinical practice.

There is also a sense that these methods work best when complemented by additional pedagogic measures. These may include:

- Supplementing simulation with early clinical exposure and facilitating active reconciliation of learning from both spheres (Bombeke et al. 2012; Yardley et al. 2013).
- Situating clinical communication within a learning paradigm (Rider et al. 2014) which acknowledges the essential presence and impact of values in healthcare which may be personal, professional, cultural, or institutional (Fulford et al. 2012). This encourages the development of learners' self-awareness and ". . .analytical and communication skills to elicit the values of individual patients and other stakeholders. . ." (Petrova et al. 2006 p. 5).
- The integration of humanities-based approaches within healthcare curricula as a further means of cultivating learners' awareness of themselves and of others, as a foundation for building caring and authentic patient relationships (Hanna and Fins 2006).

Workplace and Situated Learning

As highlighted previously learners' experience in the clinical workplace plays a crucial role in the development of patient-centred communication. Appreciating the different types of knowledge that students assimilate in formal/university settings and in clinical practice is a useful starting point when considering how best to support workplace learning.

Brown (2016b) refers to clinical communication knowledge as "codified" and "situated." Codified knowledge refers to that which emanates from academic disciplinary sources (e.g., social and behavioural sciences), including published literature and is mainly transmitted via teaching programs. Situated knowledge is generated from real-world working practices in order to meet the needs of service delivery. As students enter the workplace they are challenged to reformulate codified subject knowledge as they assimilate new context-specific knowledge and skills. Evans et al. (2010) are critical of the notion that learning can simply be transferred from one domain to another, i.e., from theory to practice. They describe how different forms of knowledge are contextualized and re-contextualized in diverse sites of learning. This construct of re-contextualization acknowledges the interplay between learner, knowledge formation, and the environment.

Lave and Wenger's (1991) theory of "situated learning" also recognizes that people think and learn differently in different social contexts, reinforcing the notion that knowledge is not a fixed, transferable, entity. They propose that learners engage in a process of "legitimate peripheral participation" within a situated group (e.g., nurses/doctors in a clinical workplace) whereby they become an increasingly involved member of that "community of practice." It is through this process, that their knowledge is thought to be constructed and re-constructed to fit with authentic workplace practices and cultural mores. This emphasis on learning as a social

practice highlights the influential role of colleagues, supervisors, and institutional norms in workplace learning.

Challenges to Situated Clinical Communication Development

The challenge of assimilating differing types of knowledge as outlined by Brown (2016b), goes some way to explaining the dissonance experienced by learners between the academic and clinical milieus. As already noted, barriers to patient-centred communication in the clinical area include environmental and human factors such as time pressures and fatigue (Bombeke et al. 2012). Barriers may also be pervasive in terms of institutional cultures and values. Hafferty and Castellani (2009) describe a complex system of influences which may manifest in medical schools, as well as in clinical learning environments, which include:

(a) The informal curriculum (spontaneous and ad hoc teaching and learning) and
(b) The hidden curriculum (organizational and cultural factors)

Messages transmitted to learners through these channels can powerfully influence their perceptions of codified knowledge and how they may re-contextualize it. This is exemplified in the reported erosion of medical students' empathy as their clinical exposure increases (Hojat et al. 2009). Learners/trainees also have difficulty gaining feedback on their communication skills in the workplace, with supervisors tending to focus on the content rather than the process of clinical encounters (Egnew and Wilson 2010). This highlights the importance of an environment in which the value of effective clinical communication is acknowledged and in which trainees are regularly observed and receive feedback from patient-centred role models (van den Eertwegh et al. 2014).

Theories of workplace learning such as re-contextualization and situated learning provide lenses through which to examine the challenges outlined above. They may be used, along with insights from research studies in the field, to inform measures to support the development of patient-centred clinical communication. These include:

- Exploring learners' existing clinical communication knowledge/skills and identifying which areas they seek to develop further
- Providing teaching opportunities in the clinical workplace to meet their learning needs
- Observing trainees'/learners' communication and providing constructive feedback
- Demonstrating and modeling in situ patient-centred practice
- Facilitating reflection, discussion, and the brokering of theoretic and work-based knowledge and practices

These measures capitalize on the opportunities afforded learners within communities of practice and actively assist in the re-contextualization of patient-centred learning as relevant to clinical reality. Evans et al. (2010) also recommend increased

partnerships between universities and clinical workplaces to encourage a collaborative approach to teaching and learning, including common goals and values.

The Patient's Voice in Clinical Communication Pedagogy

The pivotal role of patients in helping learners to appreciate and develop patient-centred attitudes and skills, within and beyond clinically based encounters, is well recognized (Spencer et al. 2011; Yardley et al. 2013). The value of early and regular patient contact within healthcare curricula has been discussed earlier and the point that "The patient's voice, as an authentic stimulus, has great authority and is more influential than the teachers" (Van Dalen et al. 1999 p.195) is well made. The introduction of Patient Educators (PEs), i.e., real patients in a formal capacity, have proved a successful means of embedding the patients' voice in healthcare education (Oswald et al. 2014). Their roles vary and may include, for example, supporting students' development of physical examination skills and how to elicit a medical history. PEs bring first-hand insights of their healthcare experiences to the learning encounter, which provides a different perspective to clinician-led teaching. Students also benefit from receiving feedback directly from patients, rather than via the proxy of simulated patients. Learners value the opportunity of hearing the patient's story and their experience of living with their condition. Student evaluations of PE programs suggest they lead to increased empathy and greater awareness of patients' perspectives (Spencer et al. 2011). PEs may also be involved in student assessment and course design/planning, though the latter are dependent on local and institutional initiatives to include patients at a more strategic level (Spencer et al. 2011).

There are additional resources available online, featuring first-hand patient experiences, which can be used to supplement clinical communication teaching. These include:

- "Healthtalkonline" (healthtalk.org 2019) This website hosts the "Database of Individual Patients" Experience of Illness' (DIPEx). People can read about others' experiences of health and illness, watch/listen to patient interviews and find reliable information about conditions, treatment choices, and support.
- "Patient Voices" (patientvoices.org.uk 2020) provides a catalogue of digitized first-person stories including those of patients, medical students, and clinicians. They may be used as reflective prompts in educational programs and as a resource for quality improvement initiatives. The organization also provides support for running locally held workshops for the development and recording of new stories.
- "Picker Institute" (picker.org) is an international charity which draws on patients' experiences to promote compassionate, high-quality care. Their website includes multiple resources aimed at informing and supporting person-centred approaches.

This brief review has outlined some of the ways in which patients actively support learners' development of clinical communication. Without this input, we risk the separation of clinical communication pedagogy from its core purpose and from the key informants of what it means to be patient-centred.

Conclusion

The first part of this chapter briefly traced the emergence of patient-centredness as a relational model in healthcare and considered a range of definitions which attempt to capture its dimensions. This illustrated the breadth of characteristics ascribed to the term both conceptually and operationally. The evidence base supporting the beneficial impact of patient-centred communication on clinical outcomes and patient experience was discussed, along with the case for patient-centredness as a moral imperative. Appreciating the background and rationale for why this model has prevailed provides a substantive foundation for the teaching and learning of clinical communication, and reflects its relation to changing medical practices and societal norms. Recognizing the intersubjective nature of clinical relationships and communication encourages us to pay attention not only to the personhood of patients but also that of clinicians. This allows for consideration of personal and professional values as part of clinical communication pedagogy, providing a rich learning context for the development of necessary skills.

The second part of the chapter reviewed the predominant pedagogic methods employed to support the development of patient-centred communication, with reference to underpinning educational theories including behaviourism, social constructivism, and experiential learning. It confirmed that clinical simulation is widely used and proven to be an effective method for the development of patient-centred communication skills. Supplementing this method with early and concurrent clinical exposure is recommended to provide students the opportunity to assimilate learning from both simulated and authentic patient contact. This can be maximized by facilitating students to reflect on, and make sense of, the dissonances they may encounter between these different learning domains. Theories of situated learning and re-contextualization and have been drawn on to help address the challenges students face in adapting their knowledge to different sites of learning. The influence of supervisors, colleagues and institutional norms as experienced through engagement with communities of practice has also been highlighted.

The crucial role of patients in supporting learners' development of truly patient-centred communication has been highlighted. While simulated patients play an important role in preparing students for (as well as supplementing) clinical practice, the impact of first-hand engagement with authentic patients remains the fulcrum for such learning. In addition to clinically based patient encounters, formalized Patient Educator programs and digitized resources provide further opportunities to learn directly from patients' insights and experiences.

A final consideration in supporting trainees' development in this area, is attending to how they themselves are treated. Creating learning environments which recognize the "Student/trainee as person," mirroring the notion of "Patient as person" can provide a meaningful congruence between clinical education and practice. This can be achieved by valuing and respecting trainees, fostering a sense of purpose and belonging in the clinical environment, actively supporting the attainment of their learning goals, and promoting self-care strategies. These measures may go some way

to offsetting the potential erosion of patient-centred attitudes that may result from the challenges and rigours of day-to-day clinical practice.

Cross-References

► Arts and Humanities in Health Professional Education

Harvey P., Chiavaroli N., Day G. (2020) Arts and Humanities in Health Professional Education. In: Nestel D., Reedy G., McKenna L., Gough S. (eds) Clinical Education for the Health Professions. Springer, Singapore. https://doi.org/10.1007/978-981-13-6106-7_49-1

► Developing Care and Compassion in Health Professional Students and Clinicians

Livesay K., Walter R. (2020) Developing Care and Compassion in Health Professional Students and Clinicians. In: Nestel D., Reedy G., McKenna L., Gough S. (eds) Clinical Education for the Health Professions. Springer, Singapore. https://doi.org/10.1007/978-981-13-6106-7_97-1

► Hidden, Informal, and Formal Curricula in Health Professions Education

McKenna L. (2020) Hidden, Informal, and Formal Curricula in Health Professions Education. In: Nestel D., Reedy G., McKenna L., Gough S. (eds) Clinical Education for the Health Professions. Springer, Singapore. https://doi.org/10.1007/978-981-13-6106-7_47-1

► Targeting Organizational Needs Through the Development of a Simulation-Based Communication Education Program

Sokol J., Heywood M. (2021) Targeting Organizational Needs Through the Development of a Simulation-Based Communication Education Program. In: Nestel D., Reedy G., McKenna L., Gough S. (eds) Clinical Education for the Health Professions. Springer, Singapore. https://doi.org/10.1007/978-981-13-6106-7_126-1

References

ACSQH. Australian safety and quality framework for health care [Online]. Australian Commission on Safety and Quality in Healthcare (ACSQHC) 2010. Available: http://www.safetyandquality.gov.au/wp-content/uploads/2012/04/Australian-SandQ-Framework1.pdf. Accessed 02 Oct 2020.

AfEE. What is experiential education? [Online]. Association for Experiential Education. 2020. Available: https://www.aee.org/what-is-ee. Accessed 04 Oct 2020.

Aspegren K. BEME guide no. 2: teaching and learning communication skills in medicine-a review with quality grading of articles. Med Teach. 1999;21:563–70.

Bachmann C, Abramovitch H, Barbu CG, Cavaco AM, Elorza RD, Haak R, Loureiro E, Ratajska A, Silverman J, Winterburn S, Rosenbaum MA. European consensus on learning objectives for a core communication curriculum in health care professions. Patient Educ Couns. 2013;93:18–26.

Balint E. The possibilities of patient-centred medicine. J R Coll Gen Pract. 1969;17:269–76.

Beach MC, Inui T. Relationship-centred care. A constructive reframing. J Gen Intern Med. 2006;21 (Suppl 1):S3–8.

Berkhof M, Van Rijssen HJ, Schellart AJ, Anema JR, Van Der Beek AJ. Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. Patient Educ Couns. 2011;84:152–62.
Bombeke K, Symons L, Vermeire E, Debaene L, Schol S, De Winter B, Van Royen P. Patient-centredness from education to practice: the 'lived' impact of communication skills training. Med Teach. 2012;34:e338–48.
Brown J. How clinical communication has become a core part of medical education in the UK. Med Educ. 2008;42:271–8.
Brown J. Behaviourism as a way of learning. In: Brown J, Noble LM, Papageourgiou A, Kidd J, editors. Clinical communication in medicine. Wiley Blackwell; 2016a.
Brown J. Situated and work-based learning. In: Brown J, Noble LM, Papageourgiou A, Kidd J, editors. Clinical communication in medicine. Wiley Blackwell; 2016b.
Brown J, Stewart M, Mccracken E, Mcwhinney IR, Levenstein J. The patient-centred clinical method. 2. Definition and application. Fam Pract. 1986;3:75–9.
Byrne PS. & Long BEL. Doctors talking to patients. London: HMSO; 1976.
DOH Liberating the NHS. No decision about me, without me. London: Department of Health; 2012.
DOH Patient and Public Involvement in Health. The evidence for policy implementation. London: Department of Health; 2004.
Duggan PS, Geller G, Cooper LA, Beach MC. The moral nature of patient-centredness: is it "just the right thing to do"? Patient Educ Couns. 2006;62:271–6.
Egnew TR, Wilson HJ. Faculty and medical students' perceptions of teaching and learning about the doctor-patient relationship. Patient Educ Couns. 2010;79:199–206.
Epstein RM, Street RL. The values and value of patient-centred care. Ann Fam Med. 2011;9:100–3.
Evans K, Guile D, Harris J, Allan H. Putting knowledge to work: a new approach. Nurse Educ Today. 2010;30:245–51.
Fernández-Olano C, Montoya-Fernández J, Salinas-Sánchez AS. Impact of clinical interview training on the empathy level of medical students and medical residents. Med Teach. 2008;30:322–4.
Foucault M. The birth of the clinic. London: Tavistock Publications Ltd.; 1976.
Friedson E. The profession of medicine. New York: Dodd, Mead and Co; 1970.
Fulford KWM, Peile E, Carroll H. Essential values-based practice: clinical stories linking science with people. Cambridge: Cambridge University Press; 2012.
Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. Acad Med. 1998;73
Hafferty F, Castellani B. The hidden curriculum: a theory of medical education. In: Brosnan C, Turner B, editors. Handbook of the sociology of medical education. Routledge; 2009.
Hanna M, Fins JJ. Viewpoint: power and communication: why simulation training ought to be complemented by experiential and humanist learning. Acad Med. 2006;81:265–70.
Hargie O, Boohan M, Mccoy M, Murphy P. Current trends in communication skills training in UK schools of medicine. Med Teach. 2010;32:385–91.
Healthtalk.Org. Healthtalkonline [Online]. 2019. Available: https://www.healthtalk.org/. Accessed 30 July 2020.
Hojat M, Vergare MJ, Maxwell K, Brainard G, Herrine SK, Isenberg GA, Veloski J, Gonnella JS. The devil is in the third year: a longitudinal study of erosion of empathy in medical school. Acad Med. 2009;84:1182–91.
Hower KI, Vennedey V, Hillen HA, Kuntz L, Stock S, Pfaff H, Ansmann L. Implementation of patient-centred care: which organisational determinants matter from decision maker's perspective? Results from a qualitative interview study across various health and social care organisations. BMJ Open. 2019;9:e027591.
Illingworth R. Patient-centredness. In: Brown J, Noble LM, Papageourgiou A, Kidd J, editors. Clinical communication in medicine. Wiley Blackwell; 2016.

Jewson ND. The disappearance of the sick-man from medical cosmology, 1770-1870. Sociology. 1976;10:225–44.
Kaba R, Sooriakumaran P. The evolution of the doctor-patient relationship. Int J Surg. 2007;5:57–65.
Krupat E, Frankel R, Stein T, Irish J. The four habits coding scheme: validation of an instrument to assess clinicians' communication behaviour. Patient Educ Couns. 2006;62:38–45.
Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. Acad Med. 2003;78:802–9.
Lane C, Rollnick S. The use of simulated patients and role-play in communication skills training: A review of the literature to August 2005. Patient Educ Couns. 2007;67:13–20.
Lave J, Wenger E. Situated learning: legitimate peripheral participation. Cambridge: Cambridge University Press; 1991.
Maynard DW, Heritage J. Conversation analysis, doctor-patient interaction and medical communication. Med Educ. 2005;39:428–35.
Mcwhinney I. The need for a transformed clinical method. In: Stewart M, Roter D, editors. Communicating with medical patients. Newbury Park: Sage Publications; 1989.
Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51:1087–110.
Mead N, Bower P. Patient-centred consultations and outcomes in primary care: a review of the literature. Patient Educ Couns. 2002;48:51–61.
Mead N, Bower P, Hann M. The impact of general practitioners' patient-centredness on patients' post-consultation satisfaction and enablement. Soc Sci Med. 2002;55:283–99.
Mishler EG. The discourse of medicine: dialectics of medical interviews. Norwood: Ablex Publishing Corporation; 1984.
Noble LM, Scott-Smith W, O'Neill, B. & Salisbury, H. Consensus statement on an updated core communication curriculum for UK undergraduate medical education. Patient Educ Couns. 2018;101:1712–9.
Oswald A, Czupryn J, Wiseman J, Snell L. Patient-centred education: what do students think? Med Educ. 2014;48:170–80.
Patientvoices.Org.Uk. Patients voices [Online]. Pilgrim Projects Limited. 2020. Available: https://www.patientvoices.org.uk/. Accessed 30 July 2020.
Pawlikowska T, Zhang W, Griffiths F, Van Dalen J, Van Der Vleuten C. Verbal and non-verbal behaviour of doctors and patients in primary care consultations – how this relates to patient enablement. Patient Educ Couns. 2012;86:70–6.
Petrova M, Dale J, Fulford BKWM. Values-based practice in primary care: easing the tensions between individual values, ethical principles and best evidence. Br J Gen Pract. 2006;56:703–9.
Picker.Org. Picker Institute [Online]. Picker Institute Europe. https://www.picker.org/. Accessed 30 July 2020.
Porter R. The greatest benefit to mankind: a medical history of humanity from antiquity to the present. London: Harper Collins; 1997.
Rathert C, Wyrwich MD, Boren SA. Patient-centred care and outcomes: a systematic review of the literature. Med Care Res Rev. 2012;70:351–79.
Rider EA, Kurtz S, Slade D, Longmaid Iii HE, Ho M-J, Pun JK-H, Eggins S, Branch WT Jr. The international charter for human values in healthcare: an interprofessional global collaboration to enhance values and communication in healthcare. Patient Educ Couns. 2014;96:273–80.
Roter D, Larson S. The Roter interaction analysis system (RIAS): utility and flexibility for analysis of medical interactions. Patient Educ Couns. 2002;46:243–51.
Salmon P, Young B. Core assumptions and research opportunities in clinical communication. Patient Educ Couns. 2005;58:225–34.
Scholl I, Zill JM, Härter M, Dirmaier J. An integrative model of patient-centredness - a systematic review and concept analysis. PLoS One. 2014;9(9):e107828. Published 2014 Sep 17. https://doi.org/10.1371/journal.pone.0107828
Skelton J. Language and clinical communication - this bright Babylon. Routledge; 2008.

Skinner BF. The science of learning and the art of teaching. In: Skinner BF, editor. The technology of teaching. New York: Meredith Corporation; 1954.

Spencer J, Godolphin W, Karpenko N, Towle A. Can patients be teachers: involving patients and service users in healthcare professionals' education. The Health Foundation; 2011.

Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995;152:1423–33.

Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam Cl & Freeman TR. Patient-Centred Medicine: Transforming the Clinical Method. Oxford: Radcliffe Medical Press Limited; 2006.

Street RL. How clinician-patient communication contributes to health improvement: modeling pathways from talk to outcome. Patient Educ Couns. 2013;92:286–91.

Szasz TS, Hollender MH. A contribution to the philosophy of medicine: the basic models of the doctor-patient relationship. JAMA Intern Med. 1956;97:585–92.

Van Dalen J, Hout JCHMV, Wolfhagen HAP, Scherpbier AJJA, Vleuten CPMVD. Factors influencing the effectiveness of communication skills training: programme contents outweigh teachers' skills. Med Teach. 1999;21:308–10.

Van Dalen J, Kerkhofs E, Van Knippenberg-Van Den Berg BW, Van Den Hout HA, Scherpbier AJ, Van Der Vleuten CP. Longitudinal and concentrated communication skills programmes: two dutch medical schools compared. Adv Health Sci Educ Theory Pract. 2002;7:29–40.

Van Den Eertwegh V, Van Dalen J, Van Dulmen S, Van Der Vleuten C, Scherpbier A. Residents' perceived barriers to communication skills learning: comparing two medical working contexts in postgraduate training. Patient Educ Couns. 2014;95:91–7.

Vygotsky LS. Mind in society: the development of higher psychological processes. Cambridge, MA: Harvard University Press; 1978.

Yardley S, Irvine AW, Lefroy J. Minding the gap between communication skills simulation and authentic experience. Med Educ. 2013;47:495–510.