

Chapter 2

The art of teaching communication skills

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It's easy to criticize us physicians for being paternalistic, for not telling the truth, for sugar-coating reality. But try to imagine what it's like when a young woman with advanced ovarian cancer walks through your door. She is 35 years old and has two kids. More than anything in the world she wants not to die. You tell her the prognosis, and that there is no good therapy for her, and she keeps saying, 'But, doctor, are you telling me there is absolutely no chance I'm going to get better?' You feel yourself back-sliding because you start thinking, 'Gee, how can I speak with that kind of certainty about anything? And how can I deny her even a tiny shred of hope?' That's when a word like 'truth' sort of loses its meaning.

Christakis NA, 2001, p.117.

Introduction

You'll forgive me if I bypass evidence-based navel-gazing about whether communication is important. Good communication in cancer is tough business, not for the faint-hearted. That's why so many times we are just too busy, too distracted, too tired or too afraid to do it well. And, like performing a Chopin Polonaise for a concert audience, it requires knowledge, competence and technical skill, delivered with commitment and passion. Not to mention managing performance anxiety. Of course communication is important. It is an art!

And if communication is an art, it follows that teachers of communication must integrate the artistic components—timing, intuition, creativity—because they are essential drivers of good clinical decision-making. In turn, the art of teaching communication skills, so as to release innate skills, involves finding ways to balance safety with challenge and engagement with objectivity. Actress Megan Cole (who played the role of Dr Vivian Bearing in Margaret Edson's Pulitzer Prize-winning play, *Wit*, and subsequently developed an academic programme for medical professionals about balancing engagement and attachment) describes it thus:

When we make conscious choices about our behaviour and have techniques for balancing our involvement and non-involvement (which is, of course, what actors do) the fear of losing the Self in the Other is greatly diminished, because we are in control at all times.

We make conscious choices...and, most importantly, we foster good relationships. Because, ultimately, good communication is about good relationships! The best doctors and nurses form meaningful relationships with all sorts of patients, under all sorts of situations. Not relationships based on the power of the clinician's personality, as illustrated by Shaw's description of Sir Ralph Bloomfield Bonnington:

He radiates an enormous self-confidence, cheering, reassuring, healing by the fact that disease or anxiety are incompatible with his welcome presence. Even broken bones, it is said, have been known to unite at the sound of his voice.

(3, p.1339)

On the contrary, great clinical communicators are characterized by relationships that resonate with understanding, sensitivity and flexibility.

Roter and her colleagues waxed axiomatically about the role of emotions in healthcare:

- (1) both clinicians and patients have emotions;
- (2) both clinicians and patients show emotions; and
- (3) both clinicians and patients judge each other's emotions (4).

The ability to judge another's emotional expressions is one of the defining facets of the concept of emotional intelligence and a cornerstone of good communication. Yet medicine has undergone a shift in culture, of which one manifestation is diminished attention to emotion and its role in the healing process.

This chapter explores core questions about teaching communication. Who are the right targets for teaching? How do we engage the people who need most help? What is the role of experience? How do we teach people to recognize and interpret their own emotion? How do we teach people to recognize and interpret emotion in others? How do we encourage people to explore beyond the human barriers that limit open communication?

The art of teaching communication

There are four essential elements to the art of teaching communication: the Task, the Learner, the Teacher and the Strategy. Linked together they look like Fig. 2.1.

The Learner: engaging the right audience at the right time

Who needs communication training? The default answer is, of course, all cancer clinicians. Cancer is a tough business and almost every encounter is fraught with emotion. In 1961, Donald Oken (5) identified the potency of the first experience of breaking bad news for young doctors—and that potency has not diminished 48 years later. In 2001, three out of four US medical trainees reported they first delivered bad news while a student or intern (6); 61% knew the patient for just hours or days; only 59% engaged in any planning; and a senior doctor was present in only 16% of cases. These young doctors rated the importance of skills in delivering bad news highly; they believed such skills can be improved and thought that more guidance should be offered to them during such activity. So the challenge is there to teach everyone.

But you cannot reach everyone; and most often you find yourself teaching the already committed. Reaching the wider community of cancer clinicians and, especially, the poor communicators, is daunting. Appeals to niceness and satisfaction are derided.

What good are doctors who empathise, smile and maintain eye-contact if they don't know their stuff?
How much better to have a brusque expert who can prescribe the right course of action.

(7, p.41)

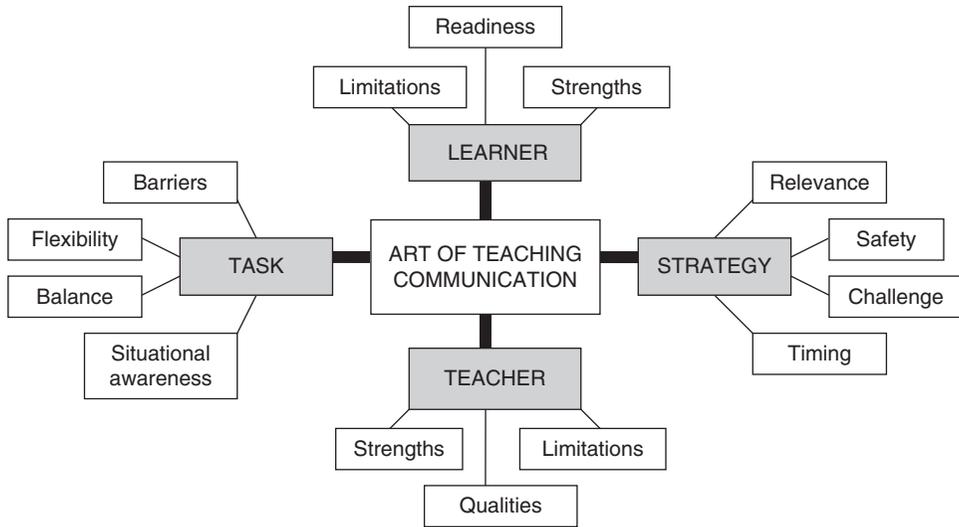


Fig. 2.1 Mind-mapping the art of teaching communication.

Of course, knowledge and competence are prerequisites; but this common and bizarre assumption that competence and compassion are mutually exclusive is consistent with neither anecdote nor evidence. Like great teachers or great concert performers, the best communicators have mastered the tools of trade.

So what will engage busy clinicians to learn more about communication? It does sometimes work to raise the spectre of litigation. A retrospective review of 444 surgical malpractice claims identified inexperience/lack of technical competence (41%) and communication breakdown (24%) as the leading system factors behind surgical error (8). The errant behaviours are well-described. For example, surgeons who convey higher levels of dominance and lower levels of concern or anxiety in their voice tones were much more likely to have been sued than other clinicians (9). In medical student examinations, standardized patients gave higher ratings when students faced them directly, used facilitative nodding, looked at them equally when talking and listening, and spoke at a similar speed and voice volume to them. Importantly, these effects remained significant after controlling for the quality of the interview content (10).

But using the threat of litigation is always a cheap shot at genuine improvement in communication; its legacy, when there is one, is most often plastic copies of learned behaviours. There is no genuineness or art. Moreover, patients see through the façade. A more universal appeal that resonates with busy health professionals, and certainly every cancer clinician, is the appeal to time management. Addressing their need to communicate with sensitivity, and with economy and efficiency, gets doctors' attention! In 2000–01, we conducted a randomized study of prompt sheets in routine oncology consultations (11). The results suggested that addressing the patient's agenda (and, in particular, the emotional agenda) at the start of the consultation, improved patient recall of information, reduced anxiety and shortened the consultation by 3–6 minutes. These are important and attractive outcomes for busy, time-poor clinicians.

We also need to face the sad reality that the art of communication will always elude some practitioners. Froelich in 1966 developed a comprehensive course for second-year medical students using a combination of a programmed manual, role-playing exercises, programmed patients and

medical interviewing films, and the writing of medical histories. He concluded that some students were simply lost causes.

Anyone who has taught in this area recognizes the impossibility of any technic (sic) or method encompassing this Art. No two situations are identical—two personalities are involved and more or less unduplicated case histories. Since this is an Art it can be taught only in sketches, and in the hope that after some hundreds of interviews as a clinical clerk and house officer a technique will evolve. Some never learn!

(12, p.288)

Leaving it to experience: inherent strengths and limitations

It would be comforting to think that experience is a reliable teacher of communication skills or, even more optimistically, that experience generates an appreciation of the art of good clinical communication. Sadly, it appears not. Each of us has a variety of communication skills acquired from childhood—through meaningful interactions with significant others and through millions of trivial exchanges with strangers. Our successes and failures in these interactions leave us with a legacy of communicative strengths and weaknesses that define the limits of our ability to engage openly and transparently with others.

A number of attempts have been made to explore psychological characteristics of both patients and doctors that might be capacity-limiting. One example is Attachment Theory (13). John Bowlby proposed that individuals' early experiences with caregivers become internalized and form cognitive models that determine, for the individual, whether they are worthy of care and whether others can be trusted to provide care. These cognitive models influence the kinds of interactions individuals have with others and their interpretations of these interactions throughout the life-cycle. The relevance to medical practice is unmistakable: doctors must form relationships with patients, with other doctors and with other health professionals.

The dismissing, self-reliant style is reportedly common among medical practitioners and one recent study has shown that *dismissing attachment* in combination with poor patient-provider communication is associated with poorer treatment adherence in patients with diabetes (14). Attachment avoidance also comes at personal cost for the doctor. Insecure, avoidant adults learn to suppress negative thoughts and feelings, but exhibit heightened electrodermal reactivity in stressful situations (15, 16). Cancer clinicians who remain unaware of their own emotional limitations thus have a toxic potential for themselves, their colleagues and those who come under their care.

Where it begins is logically where we should first intervene. Medical students are characteristically anxious about their first approaches to patients on the ward. They feel helpless, voyeuristic and intrusive. Patients want information, assistance or engagement from the student; and the students are at the bottom of the hierarchy in a big teaching hospital. They have no information, feel (quite reasonably) useless, and are scared. We address students' initial fears about approaching patients on the wards by reminding them that they bring four unique 'powers' to the encounter:

1. Ignorance: they have no information about the patient or the disease, and thus they are closer to the patient's knowledge base and able to work collaboratively from that base.
2. No clinical responsibility: patients know they can discuss clinical issues freely with someone who has no authority to make clinical decisions.
3. Strangeness: they are strangers to the patient who can choose to explore deeply personal issues (like: 'how will I tell my children?') with an objective listener.

4. Time: as first-year students, they have more time to sit with patients than they will ever have again in their careers.

When students overcome their need to be busy and helpful (in the practical sense), they begin to appreciate the wisdom of the aphorism, ‘Don’t just do something, stand there’; they find a role for themselves that makes sense (17). A focus on strengths is a solid basis for developing new skills.

The Task: learning communication at the coalface

As students enter the world of the teaching hospital or community practice, reality takes a different hold. Time becomes the great leveller and any decision that involves more time at the bedside with the patient comes under intense scrutiny. A qualitative study of empathic communication during primary care office visits found that patients seldom verbalize their emotions directly and spontaneously, tending to offer clues instead. In the majority of cases the physicians allowed both clues and direct expressions of affect to pass without acknowledgment.

The basic empathic skills seem to be recognizing when emotions may be present but not directly expressed, inviting exploration of these unexpressed feelings, and effectively acknowledging these feelings so the patient feels understood. The frequent lack of acknowledgment by physicians of both direct and indirect expressions of affect poses a threat to the patient-physician relationship and warrants further study.

(18, p.678)

We attempted to quantify these cues and oncologists’ responses using transcripts of audiotapes from almost 300 patients with heterogeneous cancers, seeing one of five medical and four radiation oncologists for the first time (19). The doctor’s response to informational and emotional cues was coded according to a standardized system. The results were less than inspiring and reflected the pressures on busy oncologists with too many patients and too little time.

Patients asked a median of 11 questions and gave two cues per consultation, usually during treatment discussions. Responses to 72% of informational and 28% of emotional cues were rated appropriate; 15% of informational and 38% of emotional cues were ignored. Gratifyingly, only 3.7% of all cues were postponed and 2.3% of all cues were interrupted by the doctor. So, busy clinicians block emotional cues as a matter of routine. This is no surprise. What is surprising is the analysis of those who did not block: informational and emotional cues were addressed *without lengthening the consultation or increasing patient anxiety*.

Pollak *et al.* (20) analysed a sample of almost 400 clinic transcripts with 51 oncologists and 270 patients. They coded for the presence of empathic opportunities and oncologist responses. In all, 37% of consultations contained at least one empathic opportunity. Oncologists responded with continuers 22% of the time, with females and younger oncologists more likely to respond. So, we have the same problem: for most patients, their emotional overtures go unanswered.

Strategies for teaching young clinicians

Against the background of innate and learned skills that young clinicians bring to medical communication, the art of teaching communication involves two key elements:

- ◆ Safety: initial interactions with patients need structure and rules so students feel safe to explore, to make mistakes and learn from them; rules can be bent later.
- ◆ Challenge: situations must be structured so as to engage students at their current level of awareness and skill, and to challenge them both intellectually and emotionally.

From a very small cluster of recent studies, there seems to be an emerging picture of the characteristics of people who demonstrate mastery of communication. Students who excel appear to be instantly recognizable to actor/patients, other students and staff. Austin *et al.* (21), in a study of empathy levels in 273 medical students, found that students who score high on emotional intelligence, and those who are good at reading the emotions of others, are perceived by their peers to be more effective in these groups. Gender, too, plays an important role. Wisikin and colleagues' study of 512 final-year medical students suggests that female students are better at communicating successfully under the stress of examination conditions (22).

Safety and challenge can be augmented by identifying students' innate capacities in problem-solving and working from these strengths. Understanding their own learning styles, for instance, allows students to focus away from their own performance and to attempt different strategies. The original Honey and Mumford classification (23) identified four learning styles: reflector, theorist, pragmatist and activist. While the psychometric properties of the scales remain debatable, they provide one means for clinicians to appreciate the potential for flexibility in responding to patient emotion (24).

The value of this sort of teaching is apparent if one examines what happens when the learning styles of doctor and patient are mismatched. Clack and colleagues found that their sample of 464 doctors differed significantly from UK adult population norms on most of the dimensions of personality measured, including their preferred mode for new learning (25). This suggests potential points for miscommunication in the doctor–patient consultation. Of the UK population, 40% preferred the *reflector* mode and would have only a 1 in 6 chance of seeing a doctor with the same preference. The 31% of doctors with preferences for the *theorist* mode would have only a 1 in 11 chance of a match with the patient. As Clack *et al.* put it:

If the two individuals involved in the interaction differ to this extent, they are likely to be talking on different wavelengths, resulting in potential misunderstandings unless there is some adjustment or 'flexing' of style.

(25, p.184)

The authors suggest that a lack of accommodation of doctors' interaction styles to these differences may partly explain complaints about poor communication, and patients' lack of understanding and poor compliance. If experienced clinicians learn how to do this through trial and error over many years, perhaps medical students may benefit from learning these differences early in their training, so they develop the ability to adjust their style more quickly.

If learning styles offer insights into how doctors manage patients, they also add to our understanding of how learners respond to teachers. Lewis and Bolden in 1989 showed that the learning styles of hospital tutors and general practitioner trainers were statistically significantly different from those of non-trainer principals and trainees. As you would expect, the tutors and trainers scored much higher on *theorist* styles. Since teachers tend to teach in their preferred learning style, there is often a mismatch with the style of the recipients (26).

The evidence for effective strategies

Communication skills training is not new (27–29). Scientific studies of communication, quite naturally, talk about outcomes and skills that are observable and measurable. But the art of communication does not begin and end with what is measurable—although evidence suggests that those who possess the art are instantly recognizable, i.e. observable. Diligent scientists have exhaustively coded specific measurable behaviours like 'head cock', and this specificity, they

argue, holds promise as an evaluation technique and better clarifies which specific behaviours are most critical in influencing patient satisfaction (30).

This confusion between process and outcomes is a core problem for meaningful research into communication training. To capture the artistic qualities of communication and communication training, we need more sensitive measures of process and we need research models beyond the purely quantitative. Small-group teaching is particularly suited for complex skills, such as communication. But, while existing work has identified the basic elements of small-group teaching, few descriptions of higher-order teaching practices exist in the medical literature (31). Ward and Stein concluded that too much teaching emphasis has been placed on content and not enough on the process of the interview (32). They argue that the doctor–patient interaction creates an interpersonal environment that determines how productive the interview will be in terms of generating accurate and natural responses from the patient. Reproducing the outcome behaviours does not generate the underlying process. Actions without objectives are aimless. We hope that models described in this book do much to redress this gap.

Communication skills can be improved by training. There have been two Cochrane reviews. One, cancer-specific, found communication skills do not reliably improve with experience alone and that training programmes were effective in improving some areas of cancer communication skills (33). A second, examining more general patient-centred training, found that interventions to promote patient-centred care within clinical consultations may significantly increase the patient-centredness of care (34). Other systematic reviews confirm that training improves basic communication skills across a broad range of training objectives, including improving the medical interview, assessment of psychological distress, imparting distressing information, counselling, problem solving and assessment of patients' needs for information (35, 36).

Other lengthy interventions confirm the efficacy of skills training but there appears to be a clear deficiency in the transfer of learned communication skills to clinical practice (37–39). What can we do about this? Razavi and his colleagues suggest:

- ◆ additional training modules;
- ◆ information about factors, both internal and contextual, that interfere with physicians' implementation of learned skills;
- ◆ role-playing exercises that focus on assessment and supportive skills.

In addition to this list, we need to address the teaching capabilities of the trainers and investigate the extent to which initial training taps into underlying issues of personal boundaries and emotional engagement. It is unlikely that initial training can be consolidated unless trainees are intensely engaged (40).

The links between research studies need more critical examination. Here is a recent example. Back and colleagues designed a residential communication skills workshop (Oncotalk) about giving bad news and discussing transitions to palliative care for medical oncology fellows (41). The pre-/post-intervention cohort study involved 115 fellows from 62 different institutions during the 3-year study. The primary outcomes were observable changes in participants' communication skills measured during standardized patient assessments (SPA), before and after the workshop. These SPA were audio-recorded and assessed by blinded coders using a validated coding system. Participants acquired a mean of 5.4 new skills in breaking bad news; for example, 16% of participants used the word 'cancer' when giving bad news before the workshop, and 54% used it after the workshop.

One critic of the Oncotalk programme argued that the acquisition of a skills set cannot be concluded to improve communication skills until the skills themselves are shown to be effective

at improving the patient experience (42). The efficacy of training, they suggested, would be better demonstrated by examining changes in the participants' real practice, recording encounters in the clinic and using patient satisfaction data as a more representative outcome measure.

Other research already confirms that there is a link between the word 'cancer' and patient outcomes (43). Simply using the word 'cancer' in a questionnaire about cancer adjustment generated anxiety to levels similar to those reported in general medical and surgical patients; however, it did not produce any distortion in reported adjustment. On the other hand, any ambiguity associated with the conditions under which adjustment was assessed, led to distortion and an increase in the patient's reported psychological distress. So there is evidence that changing this specific behaviour is an important outcome for cancer patients. Sadly, however, there is plenty of breathing space between acquiring a skill, like using a specific word, and true competence as a communicator.

Teaching empathic engagement

Since the early 1980s, the American Board of Internal Medicine has required that evidence of a candidate's humanism (i.e. integrity, empathy, compassion and respect for the patient) be provided for board certification. Many eloquent writers (whose wisdom is sadly banished by the rigours of Level 1 evidence-based reviews) have supported this view:

[Doctors]... have to treat illness rather than disease and need to understand the feelings of regret, guilt, fear, betrayal, loneliness, and other perplexing emotions that turn the same disease into different illnesses in different people.

(44, p.323)

Not surprisingly, physicians appear to be poor judges of emotion. They misread cues of patient distress and tend to rate patients' emotional state and satisfaction with the consultation more negatively than patients. Roter and her colleagues posed important questions: Will greater insight into one's own emotional responses facilitate non-verbal skill acquisition? Is self-awareness related to higher levels of non-verbal sensitivity and emotional intelligence? How might the sensitive and highly emotional issues of transference and counter-transference be best addressed within the training context? How might we best encourage and facilitate emotional self-awareness, without breaching boundaries of privacy and confidentiality?

We are not talking political correctness here. We are talking about a rational, evidence-based approach to the art of teaching communication. Our research, for example, shows that there are times when patients do not necessarily want patient-centred care, and we need to acknowledge flexibility in both patients' needs and our own responses (45).

Empathy is a respectful understanding of what others are experiencing. It is listening with the whole being! We engage with the other person and we give them time and space to express themselves fully and to be understood. Empathy can only occur when we have successfully shed all preconceived ideas and judgments about the other person. For most medical students, this is an inherently painful experience. Young doctors, sadly, lose themselves and their awareness of the power of empathy in the desire to be pragmatically useful. While some people may be more intuitively empathic in their interpersonal style, empathic behaviours can be taught. A model for the evolution of empathy is presented in Fig. 2.2.

Most interactions between patient and professional involve low emotional arousal. However, acute emergencies, diagnosis of life-threatening disease and disease progression confront the health professional with patients in high levels of distress. Fig. 2.2 identifies three categories of professional response when a patient presents with high arousal.

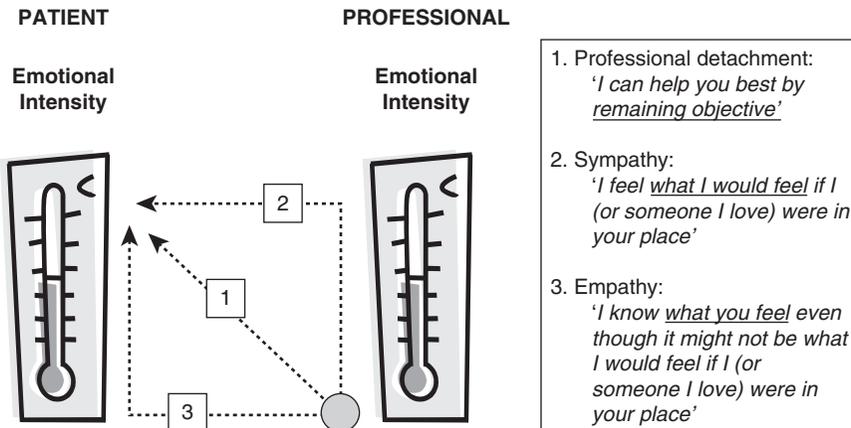


Fig. 2.2 Responding to intense emotion in the patient.

- ◆ Pathway 1 involves professional detachment that protects the doctor from becoming caught up in the patient's emotion and allows clear-headed, dispassionate decision-making. It seems self-evident that the anxious patient wants a professional who is competent and rational. The down-side—when things go wrong—is that objectivity can be re-interpreted as a lack of compassion and commitment.
- ◆ Pathway 2 describes identification with the subjective experience of the patient, 'putting oneself in the shoes of the patient'. This is sympathy and it arises from one's own life experience and one's ability to imagine how one would feel in the same situation. Medical students experience this personal anguish early in their careers when they confront real-life examples of human suffering. It is potentially burnout territory.
- ◆ Pathway 3 is empathy, the accurate appreciation of the patient's experience and emotional state, even though that might be quite different from the professional's personal response to the same situation. This is based on long experience of different people in similar circumstances. It takes time and reflective analysis to acquire.

In this model, the art of communication skills training can then be defined as activities directed at accelerating the progression from pathway 2 to pathway 3 by condensing unstructured life experience into a series of intense structured learning experiences.

The teacher

Teaching about *how to teach* is a glaring omission from most medical curricula; and it will receive limited attention here just as it does in the published literature. Yet it is the cornerstone of medical training. A study of Dutch postgraduate training in general practice (GP) failed to demonstrate acquisition of communication skills of trainees during a 27-month training period, despite the fact that skills like 'exploration of expectations and feelings' were strongly emphasized during the training (46). And why did communication skills not improve? Because the trainers were not much better! The performance of GP trainers was comparable to that of trainees, suggesting that they did not have the capacity to improve trainee performance. The Dutch authors, therefore, recommended communication skills training for the GP instructors if they are to become effective role models. It is time to question the wisdom of the dictum 'see one, do one, teach one' (47).

To finish, here is a quick exercise: think of the best teacher you have ever known. Perhaps someone from your professional education, or perhaps a high school or primary school teacher, a music teacher, a debating or sports coach! What was it that made this teacher outstanding?

Most health professionals cite from the following list of characteristics:

- ◆ patience;
- ◆ respect;
- ◆ humour;
- ◆ compassion;
- ◆ feedback;
- ◆ interaction;
- ◆ authority and engagement;
- ◆ enthusiasm and encouragement;
- ◆ awareness of teaching moments;
- ◆ emphasis on learning from mistakes;
- ◆ balance between discipline and enjoyment;
- ◆ concern with process and perspective, not just content;
- ◆ commitment to, and confidence in, the learner's experience.

Teaching communication skills is a combination of art and science. And the best teaching of communications skills incorporates all of these elements in the teaching environment. The key elements to new insight are safety and challenge. Trainees must feel safe to reflect on experience, to try different alternatives and to make mistakes, to identify individual barriers and to find new ways to overcome them. Safety comes from being with people who actively encourage the learner; who do not just tolerate error, but actively seek to exploit it to advance learning. Passion is experienced through feedback that captures the essential excitement of human communication, supplemented by a thorough knowledge of evidence-based research.

Teaching communications skills is not about teaching words or actions. It is not about technique, despite the inevitable fact that evaluation of communication skills captures mostly measurable outcomes. It is about teaching understanding of purpose and meaning. Coulehan (48) sets us a potential target for teaching that captures the art of communication: we should strive to impart emotional resilience—characterized by Coulehan as a combination of steadiness (reason and fortitude) and tenderness (humanity and compassion).

I now understand that detached concern is a risk or failure of medical education, rather than an appropriate goal. Detachment ought to be avoided because it leads to emotional numbness and a general discounting of the affective life. On the contrary, a key feature in professional education ought to be the development of what I have come to call emotional resilience, a resilience that allows one to experience fully the emotional dynamics of patient care as an essential part of—rather than a detriment to—good medical practice.

(48, p. 225)

Conclusion

The art of teaching communication skills for the clinician is about establishing practices that serve the patients' and their families' needs in a manner that is mutually fulfilling for all involved. It requires the tactful use of boundaries that are patrolled and negotiated and, at all times, mindful

of the needs of both parties. As a result, a series of conundrums can plague the teaching of communication skills. We do well to be mindful of these:

1. The balance of art and science in clinical communication fluctuates throughout medical training and experience.
2. Communication involves skills, but it is more than behavioural skills, also requiring much practical wisdom.
3. What can be measured is often far removed from the core of effective communication.
4. Flexibility is lost when we act as if communication can be reduced to simple reproducible behaviours.
5. The pressure to publish can generate a pressure to measure so that science dominates a landscape that truly incorporates both science and art.
6. Some aspects of communication are so obvious as to be banal; everyone is an expert.
7. Negotiating the boundaries of engagement and objectivity tests effective communication.
8. Personalities and learning styles common among doctors limit effective communication.
9. Undergraduate teaching operates in a context of open and timeless communication; hospitals, in contrast, demand directed discussion and transitory relationships.
10. Clinical teachers rarely have time or training to rectify poor communication in junior staff.
11. As expertise increases, the esoteric and dynamic nature of decision-making makes its description and measurement extraordinarily difficult.
12. No-one has yet described an effective training programme that captures both the art and the science of communication.

Mindful of these challenges, this book seeks to combine the evidence-base about communication in cancer and palliative care with humanity in its practice. Its goal is to integrate the art with the science. We will let you be the judge.

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