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EDITORIAL

Teaching a patient-centred approach and communication skills needs to be extended to clinical and postgraduate training: A challenge to general practice

Every day and many times a day in a GP's work, the success of a consultation depends greatly on the quality of dialogue with a patient. The GP has to win a patient's confidence and convince a person of the benefits of a medication or a lifestyle change even if no disease or symptoms yet exist. A GP if anybody has to be able to raise a discussion about difficult and sensitive topics, for example alcohol and drug use, family relationships, sexuality, or forthcoming death. Moreover, a GP has to be able to fit his/her words with anybody, regardless of age, ethnicity, or socio-economic background.

Today, it is widely accepted that a patient-centred model is the framework of a GP's work and a large body of research supports this concept [1]. Patient-centred care is acknowledged as one of the core competences in GPs' professional education and training [2,3], including good communication and interaction with patients. Teaching and learning patient-centred communication is effective when measured by process outcomes, and improvement in performance strongly correlates with patient satisfaction and adherence to care [1,4]. So far, evidence on long-term positive effects on health outcomes is scarce [4], probably because these kinds of studies have a complicated design and they demand a lot of time and resources as well.

At the Nordic Congress of General Practice 2007 in Iceland a workshop on teaching communication skills was organized [5]. The presentations and discussions showed that in most of the medical schools in Nordic countries, communication skills are taught during the first three years of the curriculum, before clinical studies. The clinical part of the curriculum is still strongly hospital based, despite many evident problems [6]. This element of the studies takes from two to three years in a medical student's life, compared with only some weeks spent in general practice.

It is reasonable to expect that a long hospital-based part of medical studies also affects students' ways of communicating and interacting with patients. Earlier findings outside the Nordic countries suggest that medical students' interpersonal and interviewing skills decline during the clinical years of the medical curriculum, despite teaching in the early study years. Recently, Nordic researchers have shown that this is what happens also in our medical schools. In Norway, Gude et al. showed that self-reported instrumental skills (task-based skills) improved linearly throughout the study years, but relational skills (skills in establishing a relationship) reached a peak in the middle of the curriculum and then declined towards the end of studies during the clinical period [7]. Respectively, Wahlqvist in Sweden showed that at the end of the curriculum doctor-centred strategy was prominent in consultation whereas relationship-building strategy was missing [8]. This happened even if the investment in teaching patient–doctor communication was large: nine weeks during the third year of studies.

What does this mean? An easy and often cited explanation is the effect of a hidden curriculum. Students more or less consciously use their hospital teachers as role models and adopt, among other things, the traditional strategy of communication and interaction with patients. Wahlqvist, however, presents in his thesis a rather wider perspective on this issue [1]. In the analyses of medical students' written accounts on patient encounters, patient-centredness was expressed in writing, despite doctor-centred performance being cited in video-recorded interviews. Wahlqvist concluded that students had adopted a patient-centred approach, but could not implement it in action at this point. In other words, their accommodation process, integration of a doctor's agenda with a patient-centred approach, was not yet completed [1].

The fact, however, that students adopt a patient-centred approach and have a positive attitude towards it gives hope for the future. Obviously, the next question to emerge is how medical education could give more support to learning patient-centredness and communication during the clinical years of the undergraduate curriculum, and also after graduation. The discussions in the workshop in Iceland clearly showed that most of the Nordic medical schools share this concern. Wahlqvist suggests

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integration of a patient-centred perspective in a student-centred learning relationship throughout clinical education, including feedback and reflection [1]. In the best case, this would happen in collaboration with teachers in other clinical disciplines. However, throughout history GP teachers have had a central role in teaching communication skills in undergraduate education and probably they will also carry the main responsibility from now on.

Another big challenge is specialist training in general practice. At the moment, patient-centredness and communication skills do not have such an important position in educational programmes as they should have, given that core elements of developing GPs' professional skills are concerned. Specific training is also needed at this stage; professional communication skills are not learnt spontaneously after graduation [9]. A goal in the future should be that patient-centredness and communication skills are an integral part of GP specialist education and training in all Nordic countries.

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