Interpersonal Communication Skills and Palliative Care: "Finding the Story Behind the Story"

Sir,

I wish to gratefully acknowledge the role of *Indian Journal of Palliative Care* (IJPC) in disseminating scientific communication for evidence-based palliative care in developing countries.[1] This letter is addressed to the readers of IJPC to enlighten the significance of practicing and training communication skills for palliative care professionals from an evidence-informed perspective "to find the story behind the story…".[2]

The American Medical Association (AMA)[3] enforced the ethical force program emphasizing patient-centered communication as follows:

"Effective, patient-centered communication is key to quality care. Good communication is both an ethical imperative, necessary for informed consent and effective patient engagement, and a means to avoid errors, improve quality, save money and achieve better health outcomes."

Effective communication should be based upon patient's underlying knowledge about their condition, and should be focused on addressing direct patient questions, denial, collusion, and anger.[4] Interpersonal communication skills are regarded as core competencies for palliative care which are important in four areas of palliative care practice: Preprocedural counseling, presenting a devastating diagnosis or poor prognosis, discussing medical error, and discussing death.[5]

Challenges in palliative care communication occur during two phases, clinician–patient interview (CPI) and breaking bad news (BBN), where two fundamental protocols act as templates or strategies, namely, the C-L-A-S-S strategy[6] for CPI and the S-P-I-K-E-S protocol[6] and the B-R-E-A-K-S protocol[7] for BBN.

Girgis and Sanson-Fisher[8] developed a multidisciplinary consensus guideline for BBN by medical practitioners, and Kumar *et al.* [9] found widely varied beliefs and practices among radiation oncologists for BBN, which eventually paved way for Martis and Westhues[10] who identified four themes for BBN in palliative care practice: (a) deciding the amount of bad news to deliver; (b) attending to cultural and ethical issues; (c) managing psychological distress; and (d) producing competent messengers of bad news.

The few extant literature reports on CPI in palliative care dealt with two major situations that may lead to collusion: [11] Transition from curative to palliative treatment and discussion of death and dying. Suryanarayana Deo and Thejus[12] described the influence of professional philosophy, professionals' attitudes and beliefs, curative–palliative transition, and four methods of communication skills acquisition (cognitive, emotional, values, and relationships) for palliative care surgeons.

Self-awareness and willingness to improve socialization skills is the basis of improving communication skills.[13]

However, effective palliative care communication often encounters few challenges such as socio-cultural variations, monetary/financial challenges, organizational challenges, and teaching communication skills for providers.[14]

Seven studies evaluated the effects of training programs on communication skills in the field of palliative care, which are reported below.

Han *et al*.[15] described an experience-based intervention to teach communication skills in giving bad news and discussing code status by using the "Palliative Care Clinical Evaluation Exercise (CEX)" in 44 residents who favorably rated the Palliative Care CEX on the following items: ease of arranging the exercise, educational value, quality of the experience, effect on their comfort with discussions, importance to their education, and value of preceptor feedback. The communication competence showed improvement 1 week after the intervention.

Faulkner[16] emphasized the use of simulators in training health professionals to improve their interactive skills since they allow health professionals to practice in a cost-effective, safe environment and to have useful positive feedback and constructive suggestion.

Back *et al*.[17] designed a 4-day residential communication skills workshop (Oncotalk) for 115 medical oncology fellows and evaluated the efficacy of Oncotalk in changing observable communication behaviors. The participants acquired better bad news skills (increased use of the word "cancer" post-training) and transitions skills.

Wilkinson *et al*.[18] evaluated the effectiveness of a 3-day communication skills course in their pragmatic randomized controlled trial (RCT) of 172 nurses who were randomized to receive the course or control intervention. There was increase in communication skills score and confidence score in favor of the course group.

Goelz *et al*.[19] conceptualized and evaluated a 15-day individualized communication skills training (CST) program on 41 physicians, which was focused on: i) communication concerning the transition to palliative care and ii) involvement of significant others in the conversation. Participant ratings confirmed the suitability, relevance, and application of the training program.

Turner *et al*.[20] assessed the staff attitudes of 109 cancer/palliative care staff while undertaking a 3-day training program and found significant differences between doctors' and nurses' attitudes to CST. The nurses had positive attitudes, and felt that CST should be mandatory, while they self-rated their communication skills higher.

Goelz *et al*.[21] randomly assigned 41 oncologists to a control (CG) or intervention group (IG) and found that participants in the IG (individualized CST on transition to palliative care) improved better than those in the CG in all three sections – transition to palliative care, global communication skills, and involvement of significant others.

Three questions arise after assimilation of extant evidence which are given below.

Firstly, AMA[22] recommends the use of Communication Climate Assessment Toolkit (C-CAT) to evaluate an organization's communication policies and practices, so as to ensure effective, patient-centered communication with people from diverse populations. The C-CAT assesses nine domains of communication: Leadership commitment, information collection, community engagement, workforce development, individual engagement, socio-cultural context, language services, health literacy, and performance evaluation. Can palliative care organizations and centers in developing countries use C-CAT as an evaluative and progress-determining tool targeted at communication skills development and implementation respectively?

Secondly, Rajashree[23] outlined the content of a basic level CST program for professionals and volunteers which should cover the following: The general introduction and the need of proper communication; common difficulties encountered by the professionals and patients in a clinical setting, which would help the student to identify the patient as a person with a disease rather than a "case"; listening techniques which encourage the patients to talk more and facilitate the interaction between the patient and the professional; and common barriers which occur in our communication practice. Can adequate efforts be initiated so that training communication skills not only become part of palliative care centers but also part of the academic curriculum?

Thirdly, the outcome measures for efficacy of training were more participant-focused rather than patient-focused. Argent *et al*.[24] described the use of validated rating scales to evaluate the verbal communication skills of health professionals before and after training. Can changes in institutional climate for communication be effectively tested using C-CAT in palliative care centers along a patient-centered approach?

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