Availability, Current issues, and Anticipation Training for Clinician-Patient Communication in Palliative Care: Learning and Doing or Learning by Doing?

Sir,

Following up on the previously published letter to editor[1] emphasizing "interpersonal communication skills in palliative care," we intend to throw light on a recently evolving training methodology that aims to improve clinician-patient communication, namely the "availability, current issues, and anticipation (ACA)" model.

Slort *et al.*[2] developed the novel ACA training program on general physician (GP)-patient communication in palliative care, which focused on the following three categories [Table 1]: Availability of the GP for the patient, Current issues that should be raised by the GP, and Anticipating various scenarios. It subsequently described category-specific factors: Six factors for Availability (taking time, allowing any subject

Table 1: Categories and category-specific factors in ACA model

Categories	Availability (A)	Current issues (C)	Anticipating various scenarios (A)
Factors	Taking time	Diagnosis	Offering follow-up appointments
	Allowing any subject to be discussed	Prognosis	Possible complications
	Active listening	Patient's physical concerns	Impending wishes
	Facilitating behavior	Patient's psychosocial concerns	Actual process of dying
	Shared decision-making	Patient's spiritual concerns	End-of-life decisions
	Accessibility	Wishes for present and future	
		Unfinished commitments	
		Discussion of treatment and care options	

ACA: Availability, current issues and anticipation

to be discussed, active listening, facilitating behavior, shared decision-making, and accessibility), eight factors for Current issues (diagnosis, prognosis, patient's physical concerns, patient's psychosocial concerns, patient's spiritual concerns, wishes for present and future, unfinished commitments, and discussion of treatment and care options), and five factors for Anticipating (offering follow-up appointments, possible complications, impending wishes, actual process of dying, and end-of-life decisions).

Two studies were reported by Slort *et al.*[3,4] The first one studied 126 GPs of whom 64 received ACA training and 64 were controls and compared the content analysis scores of Roter Interaction Analysis System (RIAS) for a videotaped 15-min consultation of each GP with a simulated palliative care patient between both groups. The second one was on 116 GP trainees of whom 54 received ACA training and 64 acted as controls. Both studies did not find any effect of ACA training on the RIAS scores, either on the number of issues discussed or on the quality of GP or GP trainees' communicative behavior.

Although the ACA approach was developed and studied by same group of authors, and was surprisingly shown to be ineffective, it is yet to be content validated and cross-culturally adapted to suit the scenario in developing countries. The ACA model appears to be comprehensive and patient-focused, but the studies on its effectiveness did not measure patient-focused outcomes, or were not on real patient population, or on interdisciplinary training, which are scope for future research in this area.

The major concerns in using this model in the palliative care settings of developing countries include the level of knowledge and practical skills in the application of ACA model, perceived professional/provider attitudes, and patient/caregiver preferences and their experiences, which are to be taken into consideration prior to its use in the palliative care settings of developing countries.

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Access this article online

Quick Response Code:

Website: www.jpalliativecare.com

DOI: 10.4103/0973-1075.138405