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PROGRAMS TO IMPROVE DOCTOR'S COMMUNICATION LITERACY

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Abstract

Successful communication in the doctor-patient dialogue often is the key to establish a trusting relationship between the doctor and the patient, resulting in a positive dynamic of patient recovery. The need for in-depth study of strategies and tactics of the doctor's speech behavior is due to the shifting focus of modern medicine from the patient's disease to his personal characteristics, i. e. it is not the patient's disease that acquires great value, but the person himself. Patient-oriented approach dominates in the USA and most European countries, while in Russia the paternalistic model of communication is still the predominant one. For this reason, in addition to developing professional skills, one of the priorities of medicine is also to improve knowledge in effective communication. This article explores the problem of introducing programs to improve the communicative literacy of doctors. The paper presents a brief overview of educational programs for developing the communication skills of doctors in Russia, the USA and Europe, approved at the legislative level, identifies strengths and weaknesses of the methods of implementing these programs in the practical medical activity and presents their comparative characteristics. As a good example, the study describes the results of the communication method implementation reviews and successful projects. The article emphasizes the necessity of conscious and purposeful use of communication methods when working with patients, as well as increasing the education level not only of medical personnel but also of patients themselves.

Keywords: Communication strategies, doctor-patient communication, human-centred consultation, patient-oriented approach, psychological health of the population.

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1. Introduction

The intensification of introducing the patient-oriented method in medicine resulted from a new approach to the perception of the patient's personality. The treatment considers not only the symptoms and stage of the disease, but also the psycho-emotional state of the patient, his fears, social situation, awareness of the disease. In the 1970s, diagnosis and successful treatment required only to have in-depth theoretical knowledge, to conduct a medical examination, to make a single decision about treatment methods, and follow the rules for maintaining records. Today, these competencies include mastery of professional communication skills to meet the demands of modern society in the medical field. For successful interaction with the patient, the doctor needs to penetrate the patient's mind, assess what knowledge he or she has on the subject, how correct these ideas are (after all, false information that patients easily find on the Internet can lead to a distorted view of the disease and the patient's refusal of treatment), give explanations and comments, without using complex professional terminology, argumentatively persuade, provide the patient with several options for treatment and take the final decision together with the patient. In Europe and the United States, a communicative approach to patient care is a priority and fast-growing area to ensure access to the above competencies. In Russia, however, only a narrow range of specialists use this approach, and it is not introduced everywhere.

2. Problem Statement

In the United States and some European countries, mastering communication skills by medical professionals is a mandatory part of the educational program. For this reason, training courses to improve patient communication skills must be confirmed by special certificates issued after successful completion of examinations (Batalden et al., 2002; Horowitz, 2000). Russian educational standards often mention that a doctor should learn the skills of effective communication and master communicative strategies of communication with patients (Order No. 95 and No. 514). However, the question of how young specialists can develop communicative competences remains relevant if the educational program does not provide a separate discipline for improving these competences.

3. Research Questions

Due to the fact that Russian medicine is oriented mainly at the paternalistic communicative model, but (both in the field of practical medicine and at the level of educational standards) there are already visible tendencies of transition to the patient-oriented model of communication, the tasks of this study include: 1. to consider the peculiarities of the patient-oriented approach and its fundamental element - human-centric consultation, in developed European countries, the USA and Russia; 2. to give a comparative description of the implementation of the patient-oriented model.

4. Purpose of the Study

The purpose of the study is to consider ways to implement and apply strategies and tactics of speech behavior of doctors within the patient-oriented approach in Russia, USA and Europe. For the most

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part, we take programs of the USA as a comparative unit, because, firstly, it was here that this direction was first recognized as a priority (which, on the one hand, is due to the commercialization of medicine, on the other hand, with the desire to improve the quality of medical services and ensure the stabilization of the patients' emotional state), and secondly, it is in the USA that patient-oriented medicine is most intensively used in practice. The object of the research is educational programs and teaching aids for doctors on the development of communication skills and mastering strategies and tactics of speech communication.

5. Research Methods

To solve the tasks the work uses a pragmatic analysis of educational standards related to developing communicative competencies of medical personnel. It uses a descriptive and interpretative approach to review existing programs and training for improving communication skills with patients. The method of systematization and evaluation serves to present a patient-oriented approach.

6. Findings

Numerous studies have shown that patient satisfaction with the quality of medical services often depends on the communication skills of the doctor. In this connection, in Europe and America there is an active development of special programmes and testing of courses to improve the communication skills of specialists. These courses are relevant both for medical students beginning their professional career and for active doctors (Modi et al., 2016). Europe and the USA particularly value the importance of communication skills. At the academic level, there is an interdisciplinary approach to the study of medical discourse strategies, with a separate course introducing the basics of verbal and non-verbal medical communication (Vogel et al., 2018). Since 2005, the Medical Licensing Exam (USMLE), which allows practicing medicine in the USA, has introduced a section to test the practical communication skills of a future specialist, which he applies to work in standard, unusual and stressful situations. The USA also has an Accreditation Council for Graduate Medical Education Programs (ACGME), which checks the quality of developed programs and their practical application (Batalden, et al., 2002; Horowitz, 2000).

Educational standards of the Russian Federation suggest that students of medical institutions should master not only professional competencies during their studies. On the Portal of Federal State Educational Standards for Higher and Secondary Education, the orders approving the Federal State Educational Standards for 2014 and 2016 contain the following list of competencies for the " General Medicine" direction: 1. general cultural competencies, 2. general professional competencies, 3. professional competencies (medical activities, organizational and management activities, research activities). When describing competencies, there is a focus on communication skills to be learned during study. The future specialist should "apply techniques and methods of effective communication in professional activity; use the methods of self-regulating behavior in interpersonal communication", as well as know "the relationship between communication and activity; goals, functions, types and levels of communication; roles and expectations in communication; types of social interactions; mechanisms of mutual understanding in communication; techniques and methods of communication, rules of listening,

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talking, persuasion; ethical principles of communication; sources, causes, types and methods of conflict resolution" (Order No. 95 and No. 514).

The main difference between the Russian and foreign approach is, firstly, the attitude towards communication competences. In Russia, these competences are not considered as practical, but rather remain theoretical and far from practical. Secondly, the differences are in ways of implementation at the academic level. Abroad, there is an interdisciplinary approach to mastering the strategies and tactics of speech behavior by medical personnel in a variety of subjects. In addition, they have developed separate specialized courses, and the attestation in the end of it to assesses the ability of the doctor to correctly communicate with the patient. The existence of the exams required to start a medical career speaks to the seriousness of the West and the USA towards communicative competences. To master the skills of communication with patients, the Russian FSES assumes one single discipline, Psychology of communication, whose passing is in most cases assessed by the rule of pass/fail. Thirdly, in Russia, compared to foreign countries, there is practically no well-established system of educational programs and courses to improve the communicative competencies of active doctors.

6.1. Basics of a patient-oriented approach

Increased attention to doctor's communication skills comes from personalized medicine and the evolving patient-oriented approach (Paving Way for Personalized Medicine, 2013; Santana, et al., 2018). Personalization refers to the selection of diagnostic, therapeutic and communication strategies for an individual patient, based on his/her genetic characteristics and social context, in other words, psychological, cultural and gender aspects. This also includes the patient's general level of education and his/her awareness of the disease. This will determine the adjustment of communication strategies and tactics applied by the doctor in direct contact with the patient (Taratukhin, 2016).

Improving the quality of medical care does not depend only on the doctor who diagnoses the disease. The long-term effect of the therapy requires the patient's own efforts. It is important that he adheres to the doctor's recommendations, knows how to monitor his health, gives adequate feedback to the doctor, independently engaged in the prevention of diseases, including chronic ones, and has a desire to live a healthy lifestyle. The patient-oriented approach involves the patient in the process of planning their treatment and relies on a mutually beneficial partnership between the doctor, patient and interested family members. The first steps towards a joint decision on treatment methods begin at the first consultation, where the doctor creates an atmosphere of understanding and trust, thus laying the foundation for further friendships with the patient (Elwyn et al., 2016).

Foreign literature refers to such consultation as "human-oriented medical consultation". In such a consultation, the personality of both the doctor and the patient is important. The doctor's task is to create a favorable psycho-emotional microclimate formed mainly due to pre-conceived speech actions of the doctor. Numerous sociological surveys have shown that psychological recovery and, to some extent, physical recovery depends on the doctor's personality causing sympathy and trust from the patient, while patient satisfaction with the quality of services is directly related to how quickly the doctor is able to establish contact with the patient. The main task is to learn as much as possible about the patient's personality, fears and feelings about the disease. While prescribing therapy, it is important to consider the social aspect, especially financial possibilities and cultural peculiarities (Đorđević et al., 2012).

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Verbal communication consists in the fact that the doctor constantly asks clarifying questions, openly discusses with the patient options, benefits and risks of treatment, interests the patient's opinion, and considers his wishes. The consultation most often ends with a diagnosis and a summary of a clear treatment plan, recorded in writing. During the consultation itself, it is desirable not to interrupt the patient, but to make comments during pauses. This approach makes the patient feel that he or she is not indifferent to the doctor and therefore gets in touch more quickly. The non-verbal part of communication consists of the ability to keep eye contact and to catch the patient's mood by the expression of his face. An informed application of communication strategies and tactics by a doctor also requires appropriate patient literacy. This includes not only the ability of the patient to ask questions, to not be afraid to specify or seem ignorant, but also the ability to demonstrate understanding, agreement or disagreement, and to express the perception of their own illness. Patient's own provision of information helps the doctor to get to know the patient's identity better and reduces the consultation time, helps the patient to feel useful and meaningful (Đorđević, et al., 2012; Kurz, 2002).

In the speech plan, the "human-oriented interview" usually consists of open questions. American experts suggest starting a consultation conversation with the phrase: "How can I help you?" This open question allows the patient to determine the direction of the conversation. When implementing this concept, it is very important not to interrupt the patient, but to let him tell the whole story that led him to the doctor's office. Most patients on average only take two minutes to explain why they came to the appointment. During this time, the patient gives almost 80% of the necessary information. However, statistics show that doctors interrupt patients every 18-23 seconds (Kurz, 2002).

6.2. Applying a patient-centric approach in Russia

In Russia, the patient-centered approach is not yet recognized as a priority in doctor-patient communication. If a doctor introduces elements of this approach in conversation, his verbal actions are most likely based not on knowledge of specific communication methods, strategies and tactics, but on many years of experience. Many studies, mostly conducted by foreign colleagues, show that the distinctive feature of doctor-patient communication in Russia is that it is the doctor who determines the course of a conversation with the patient and most often makes a sole decision about the methods of treatment, while explaining the diagnosis using complex medical terminology.

In Russian reality, the predominance of the paternalistic model of communication is due not only to the unpreparedness and lack of knowledge of doctors about the basics of the patient-oriented approach, but also to the unwillingness of patients themselves to take some responsibility for the decision taken. Koerfer and Albus (2015) introduce the concept of the so-called "emancipated" patient, i.e. an equal, well-informed, educated patient with a mentality that allows for participation in the decision-making process. The medical discourse is currently forming the term "responsible patient", which should become the equivalent of "responsible citizen".

Despite the fact that FSES assumes only one discipline (Communication Psychology), which provides for training and "refreshing" communication skills, some medical educational institutions are aware of the need for an interdisciplinary approach to the issue of mastering communication skills. For example, in 2017 the International School of Doctor as a Humanist was established on the basis of the Institute of Linguistics and Intercultural Communication of I. M. Sechenov First Moscow State Medical

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University, which aims to return the humanitarian and communicative foundations to medicine, both at the level of education and at the level of practical activity of doctors (Markovina & Fedorovskaya, 2018; Wald et al., 2019).

Since 2018, the Institute has regularly held seminars for senior students to improve their oral communication skills in a foreign language, modeling near-reality situations developed on the basis of authentic doctor-patient dialogues. The task of such seminars is not only to work out standard (and sometimes difficult) communication situations in a foreign language, but also to prepare students for internships abroad. There is also the improvement of communication skills as part of the program of additional professional education "Interpreter/translator in the field of professional communication". This program allows students not only to get a second higher education along with basic medical one, to improve their language skills, but also to master communication strategies and tactics of consulting conversation. Most of the program materials are based on authentic patient consultations (Imo et al., 2020).

6.3. Communication skills for improvement and complexity of program implementation

To improve professional medical communication skills, it is important to understand which ones are fundamental, necessary for the mutually beneficial exchange of information. Specialists identify three types of basic skills: content transmission skills, information transmission skills, and perception skills that are closely related and affect not only each other but the quality of communication in general (Kurz, 2002).

The skills of content transmission include the doctor's understanding (or even awareness) of what information he or she provides to the patient. During the consultation conversation, the doctor should constantly check whether the content of the remarks is clear to the patient, whether this type of explanation is appropriate for the patient, how accurately the patient answers the questions and how informative the answers of the patient are, and if not, whether it is related to the wording of the question.

The skills of the information transmission include the ability to structure the consultation using different speech indexes and transitions that facilitate the perception of information. For example, introductions of adverbs formed from ordinal numerals (first, second ...), different types of questions, pauses and logical accents in the text create a structural form of speech.

Perceptual skills mean the processes of thinking and feeling, awareness of decisions made, the ability of listening to the patient to the end, consoling, giving hope, cheering. This also relates to the doctor's ability to identify factors that interfere with the patient's perception of information or distract the doctor himself. Sometimes patients refuse to go through prescribed procedures or take medication after they have seen a doctor and received a recommendation, and patients do not always inform the doctor of their decision. This leads to dissatisfaction of patients with the quality of services provided. Therefore, to develop a correct treatment plan that the patient will follow, it is necessary to understand the reactions and emotions of the patient to offer an alternative therapy option in time.

These skills allow the doctor 1. to clearly represent his or her weaknesses in communicating with the patient, 2. to establish relationships with the patient, 3. to create a friendly atmosphere of communication, 4. to evaluate the patient as a unique personality, 5. to determine the social and

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psychological situation of the patient, 6. to develop optimal methods of obtaining information, 7. to determine the share of participation and interest of family members and friends, 8. to provide emotional support, 9. to provide greater access to medical care, 10. to instruct on preventive measures in case of hibernation (Scholl et al., 2014).

The pragmatic mistake frequently made, even by experienced doctors, is that they take strategies and tactics to communicate with the patient from personal experience. The fact is, our psyche is unable to perceive its own communication. One survey of 700 doctors and 807 patients showed that 75% of doctors appreciated their communication skills, while only 21% of their patients were actually satisfied with the results. Another proof of the imperfection of one's own experience and sensual perception is a study whose main question was how much time doctors spend training patients during a twenty-minute consultation. The doctors believed that they spent at least nine to ten minutes on it. However, an analysis of the audio and video footage from the counselling sessions proved that doctors spent less than two minutes (Tongue et al., 2005).

Understanding the need to train such communication skills benefits not only patients, but also the doctors themselves. Doctors with many years of experience recognize that the lack of theoretical knowledge in communication and the nuances of dialogue leads to rapid emotional burnout, low performance. There are also symptoms of depersonalization and other psychological disorders.

6.4. Examples of the introduction and evaluation of communicative literacy programmes for doctors

The analysis of various patient surveys shows that positive feedback is determined not by the actual quality of the service, but by the communication skills of the doctor. Since it is not always possible to master many principles of consulting conversation based on one's own practical knowledge, it is necessary that the practice of doctor-patient communication starts already in an educational institution and needs to be integrated into educational programs on an interdisciplinary level. The presence of pilot projects being developed for the Association for Medical Education in Europe proves that it is possible to learn communication skills purposefully.

One factor that prevents a specialist from mastering good communication skills on their own is that patients very rarely leave adequate feedback about the doctor (and more often do not leave any feedback at all). A patient can only leave a "qualified" opinion about a doctor if he or she understands the principles of building a conversation and is willing to cooperate, i.e. is an educated, capable patient. The programs and trainings for the promotion and implementation of the patient-oriented method require methodological guidelines and an understanding of the specifics that need to be taught by doctors. The Calgary Cambridge Model of Medical Consultation is one of the most famous quick reference guides for the implementation of primary consultation and is the basis for the creation of numerous courses for the training of medical professionals, which most often include a detailed diagram of medical consultation and speech patterns that are useful at one stage or another (Kurz et al., 2004).

One example of an effective course is a three-day course to improve the communication skills of oncologists, followed by a three-month observation of their consulting activities. 160 doctors from 34

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cancer centers in the UK attended the training. The video and audio recordings of the counselling sessions as well as feedback from 2407 patients were analyzed to summarize the results (Fallowfield et al., 2002).

The doctors were divided into four groups. Participants of the first group took a communication skills course and then received written feedback (group A), the second group took only the course (group B), the third group of doctors received only written feedback (group C), in the fourth group doctors did not take the course and did not receive written feedback (group D).

Participants were trained in small groups (3-5 people). First, doctors listened to short lectures on the theory of medical communication, then developed solutions for standard and difficult situations, and finally, using a role-playing game with "trained" patients (who were mostly professional actors) staged these situations. At the end of the game, doctors, firstly, received constructive feedback from the "patients", and secondly, jointly watched the video with their staged consultation and all together discussed the results. After that, for three months, the video recorded real doctor's consultations (of course with the patient's consent).

The feedback consisted of: 1. a written review of the doctor's communication skills made from the analysis of his consultations; 2. patient questionnaires reflecting their satisfaction with the consultation with brief comments; 3. a comparative analysis of the doctor's satisfaction with his work with the patient and the actual satisfaction of the patient; 4. lectures on the theory of professional medical communication; 5. a list of standard language formulations and questions that can be used in practice; 6. bibliography and references.

Doctors who took the course (groups A and B) demonstrated higher communication skills (compared to doctors from the other two groups) not only when working in standard, but also in conflict situations. Participants of the first two groups also reported a greater degree of confidence in working with patients. They also managed to correct most of the typical errors. For example, the number of closed questions decreased and the number of directing and open-ended questions increased, doctors began to pay more attention to patients' non-verbal signals, anticipating questions and giving empathic answers. This behavior of the doctor contributed to the patient's trust, thus facilitating the selection of individual therapy tailored to the patient's wishes.

Due to the fact that a patient-oriented approach requires some preparation not only from doctors, but also from patients, WHO has proposed an educational program aimed at preserving the psychological health of the population (synonymous with psychological health is the "mental" or "spiritual", sometimes, "mental health"). The WHO Constitution defines health as: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The main drivers of non-communicable diseases are psychological problems, influenced by social, cultural and economic factors. Only comprehensive measures can solve mental health problems. The promotion of literacy programmes in the field of treatment and prevention of psychological health should be done not only at the national level, but also internationally (Patel & Chatterji, 2015).

7. Conclusion

Personalization of medicine and its patient-oriented approach can only become a practical reality if the two sides, the doctor and the patient, are ready for it. The doctor should extract the most useful

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aspects from the consultation conversation and, most importantly, know the communicative approaches to the personality (informating, verbal expressions of empathy and empathy). The patient, in turn, should perceive the information, discuss possible solutions, self-educate and take responsibility for the jointly adopted therapy plan.

Communication competences undoubtedly form the core of the patient-oriented approach mainly used in the USA and Europe. Interest in this approach is due to the positive results of educational programs and training to develop communication skills among doctors. Positive results are manifested primarily in the rapid pace of patient recovery and greater satisfaction with the provided services.

The use of the patient-oriented approach in Russia, where the paternalistic, or parenting approach still prevails, is rare rather than permanent practice. Nevertheless, the introduction of a paragraph in the FSES about improving the communication skills of doctors indicates the urgency of the issue concerning the speech behavior of medical personnel.

Foreign specialists agree that the implementation of this approach is quite a labor-intensive process, which requires not only practical experience, but also targeted study of strategies and tactics of communication with certain social and age groups of patients. The difficulty in implementing this approach may also lie in the psychology of the doctor and the patient. Both must be committed to working together and making decisions (Tongue et al., 2005).

We should not forget that having knowledge as such cannot ensure its correct application. There is a need to introduce disciplines at the academic level that provide mastery of communication approaches, strategies and tactics of speech behavior. Doctors must have a clear understanding of the need to assimilate, improve and adjust existing communication skills that have been accumulated over the years.

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