**2013 Health Reform**

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# Improving the quality of healthcare communication

## A national policy for establishing a patient-centred culture of communication

**Passed by the Federal Commission on Health System Governance on 1 July 2016**

## Imprint

**Prepared by the Project Group on the Quality of Healthcare Communication**
Magdalena Arrouas, Federal Ministry of Health / Bundesministerium für Gesundheit und Frauen
Christina Dietscher, Federal Ministry of Health / Bundesministerium für Gesundheit und Frauen
Mario Földy, Vienna Hospital Association / Wiener Krankenanstaltenverbund
Christian Halper, Federal Ministry of Health / Bundesministerium für Gesundheit und Frauen
Peter Haubenberger, Social Insurance Authority for Business / Sozialversicherungsanstalt der gewerblichen Wirtschaft (from 02/2016)
Georg Palmisano, Upper Austrian State Government Office, Directorate for Social Affairs and Health, Department of Health / Amt der oö. Landesregierung, Direktion Soziales und Gesundheit, Abtl. Gesundheit
Jürgen Soffried, Institute of Health Promotion and Prevention on behalf of the Insurance Authority for Railways and Mining / Institut für Gesundheitsförderung und Prävention, im Auftrag der Versicherungsanstalt für Eisenbahnen und Bergbau
Stefan Spitzbart, Main Association of Austrian Social Security Institutions / Hauptverband der österreichischen Sozialversicherungsträger
Ruth Taudes, Social Insurance Authority for Business / Sozialversicherungsanstalt der gewerblichen Wirtschaft (up to 02/2016)
Sylvia Türk, Federal Ministry of Health / Bundesministerium für Gesundheit und Frauen

and

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Marlene Sator

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# Summary


## Background and goal

As a **top-priority measure to implement Health Target 3 "Enhancing health literacy in the population"** (B-ZV, Art. 8, Operational goal 8.3.2), the Committee on Public Health commissioned a project group to draw up the policy presented here on improving the quality of healthcare communication for all partners involved in the 2013 Health Reform.[1]

The goal of the policy is to **foster a culture of good quality healthcare communication, including awareness of the processes it involves** and, in doing so, to support the broad range of initiatives in this field. The policy presented here ties in with various agendas in the process of health reform and can also contribute to its successful implementation. It formulates fields of action for the medium- and long-term development of good quality healthcare communication but does not lay down any concrete proposals for its implementation as these can only be planned in cooperation with the key players in the healthcare system.

## What is good quality communication?

Good quality healthcare communication involves four main dimensions, all of which should serve as targets for future development initiatives: a **linguistic-interactive dimension (communication techniques)**, a **content-related dimension (medical aspects)**, a **psychosocial dimension (relationships)** and the **context in which the communication takes place (settings)**. Based on the available evidence and a fundamental orientation towards the model of patient-centred health care, communication between health professionals and patients can be understood as a **key instrument in care, diagnosis and therapy**. Good communication can be taught and learnt; it can be supported and guided structurally. Effective communication between health professionals and patients should therefore be understood as an essential task and responsibility.

## Why is good quality communication important?

The scientific literature has demonstrated that communication between health professionals and patients is **extremely relevant for healthcare outcomes**. Good communication has positive effects on the patients' state of health and their health-related behaviour, patient satisfaction and patient safety as well as on the number of lawsuits relating to medical malpractice, the health and job satisfaction of employees in the health services and the financial impact on patients, doctors and the entire healthcare system.


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1 As their starting point, the project group took the results of the preliminary research presented in two long reports (Sator et al. 2015a; Sator et al. 2015b) and a shorter summary (Sator et al. 2015c) which synthesized the evidence for the analyses underlying this policy.

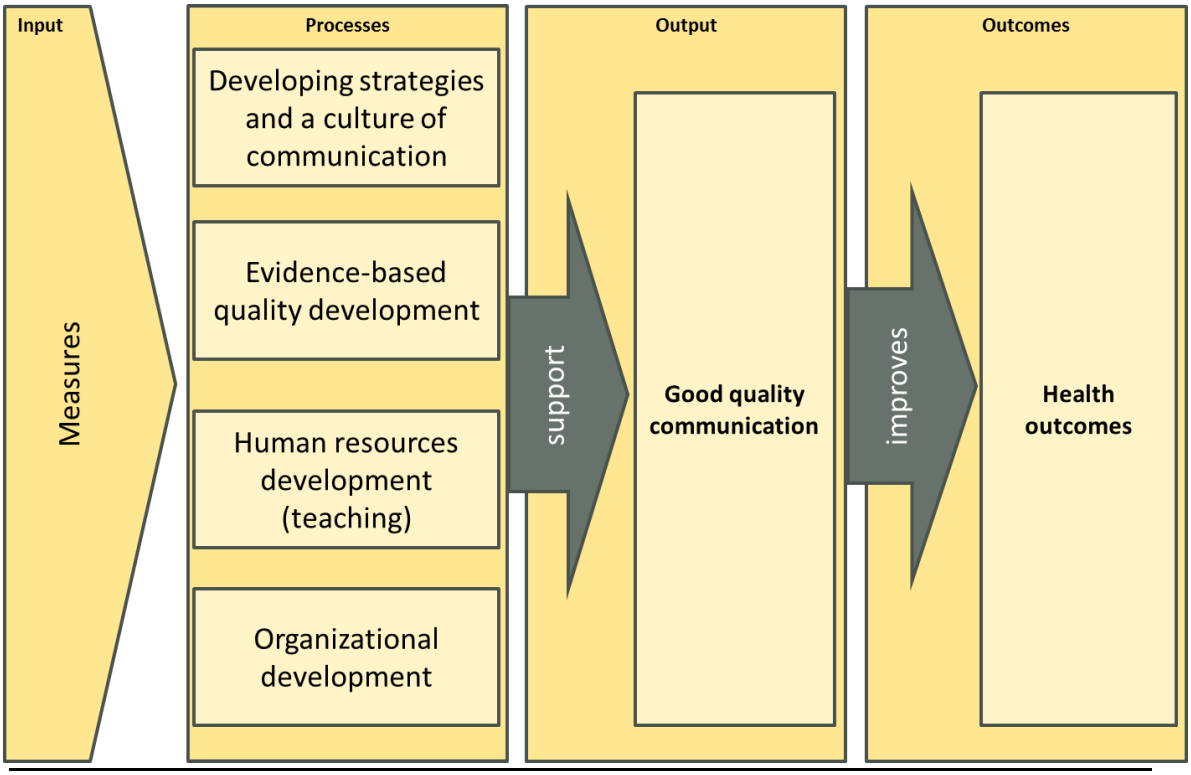
### What is the status quo in Austria?

Patient surveys on doctor-patient communication carried out throughout Europe, linguistic analyses and interviews with experts have all revealed that **the quality of communication in Austria is below average within the EU.** Even though communication skills have become part of medical education programmes, they should play an even more important role in everyday patient care. Although there are a number of 'one-off' initiatives to improve this situation, most of them depend on the commitment and motivation of individuals and are often only of limited duration. Consequently, there are virtually no systematic procedures to implement nationwide.

### Intervention model and strategic recommendations for action

The overarching **goal is to improve health outcomes**. The quality of healthcare communication is a very important determinant of the desired quality of these outcomes. Factors which influence the quality of communication can be identified in four fields of action and recommendations for action can formulated for each field.

Figure 0.1:
Intervention model on improving the quality of healthcare communication




Source and illustration: Project Group on the Quality of Healthcare Communication

### 1. Developing strategies and a culture of communication (policy)

In view of the fact that **a common understanding by all stakeholders** of the significance of the quality of healthcare communication and of developing communication skills in undergraduate/postgraduate/continuing medical education is decisive, it is recommended that

» strategic public relations campaigns are carried out on this topic,
» strategic alliances for good communication are formed with relevant partners,
» a consensus statement is drawn up with all relevant stakeholders on the implementation of developing communication skills in undergraduate/postgraduate/continuing medical education to encourage them to implement reforms in their own areas of responsibility,
» effective communication is established as a priority issue in the implementation of national policies and programmes.

### 2. Evidence-based quality development

In view of the fact that the **quality of continuing education courses** on communication for health professionals differs radically at present, it is recommended that

» quality standards[2] are drawn up for communication skills and how they are taught,
» example curricula are drawn up for communication skills training in continuing education,
» the quality of continuing education courses for communication skills is guaranteed and
» patient information leaflets and decision aids are designed to be effective.

### 3. Human resources development (teaching)

In view of the fact that there is evidence of unsatisfactory implementation of communication skills by health professionals in their everyday clinical practice, it is recommended that

» senior health professionals and teaching staff on undergraduate and continuing education courses should upgrade their qualifications in relation to communication skills,
» a continuing education initiative is launched for practising health professionals,
» evidence-based patient education programmes should be carried out.

### 4. Organizational development

In view of the fact that many **beneficial factors** for good communication in the healthcare system and its institutions are lacking at present, it is recommended that

» effective communication is incorporated in organizational terms,
» the structures and processes for everyday communication are reorganized and conditions for communication training as well as for assessing communication skills in practical training are improved,

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2 The concept of quality standards should be understood in a broad sense here and **not** in the narrow sense of "federal quality standards" (in accordance with the Act on Health Care Quality).

» the educational establishments responsible for implementing communication modules in practical training are given systematic support,
» information and communication technologies are used as support for communication between health professionals and patients and not as a replacement.

### Further stages of implementation

The Federal Annual Work Programme for 2016 (operational goal 8.3.2.; measure 2) already stipulated that the step-by-step implementation of this policy should begin in 2016 with the **involvement of the Austrian Platform for Health Literacy and the relevant committees on Public Health and Quality**.

The implementation process should follow the Public Health Action Cycle: once the policy has been adopted and widely disseminated, the prioritized recommendations for action should be **turned into concrete measures step by step in close cooperation with the relevant stakeholders** (medical education institutions for all healthcare professionals, hospital authorities, professional interest groups and expert associations, patient advocacy groups, etc.). In doing so, the accountabilities and responsibilities of the system partners (federal government, provincial governments, social security institutions) for the policy have to be made explicit in relation to finances, chronology and personnel. Special funding will be necessary in order to develop and realize concrete measures for implementation together with the stakeholders. The prioritized measures for implementation should be evaluated and the overall effect of the policy should be assessed.

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# 1 The quality of healthcare communication as a component of health reform

## Background

Aligned with a series of health targets, overall policy in relation to the promotion of health should gradually increase the number of healthy life years people in Austria can expect to live over the next 20 years. Health Target 3, "Enhancing health literacy in the population" has been identified by the Federal Health Commission as having top priority (www.gesundheitsziele-oesterreich.at).

In 2013, the working party responsible for Health Target 3 pointed out that interaction between health professionals and patients is a very important process and one in which health literacy is not only required but also developed. Successful communication includes the people concerned (patients and their relatives) being able to articulate their health problems, understand the various options for therapy, take joint responsibility for decisions made about treatment and understand their own role in the chosen course of treatment in order to successfully deal with their health issue. Vital decisions are made jointly by health professionals and patients on the patients' status, diagnoses and therapies and, consequently, on the resources which are to be used.

As part of a measure related to Health Target 3, Gesundheit Österreich GmbH was commissioned by the Federal Ministry of Health and the Main Association of Austrian Social Security Institutions to provide the preliminary research, analyses and initial recommendations relating to broad improvements in the quality of communication in health care in Austria; at the same time, relevant practice models and development initiatives were analysed in Austria and abroad.[3] **The two long reports provide the scientific foundations for this joint policy paper for all partners involved in the 2013 Health Reform.** As a basis for the *strategic recommendations for action*, the following questions in particular, namely *What is good quality communication?*, *Why is good quality communication important?* and *What is the status quo in Austria?* as well as determinants of good quality communication were covered in detail in these preliminary research reports. These reports should be consulted for scientific evidence relating to the preliminary research on which this policy is based. The strategic recommendations for action formulated in this policy paper relate to international practice models which were also presented in the preliminary research.

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The results of this preliminary research are presented in two long reports (Sator et al. 2015a; Sator et al. 2015b) and a shorter summary (Sator et al. 2015c).

## Links to the 2013 Health Reform (Zielsteuerung-Gesundheit)

The policy described here ties in with various agendas in the 2013 Health Reform and can also contribute to its successful implementation particularly in relation to

» defining mandates for medical provision and the distribution of roles particularly in multiprofessional primary health care (operational goal 6.1.2.),
» defining competence profiles as well as basic and advanced medical education programmes for healthcare professionals (operational goal 6.3.1.),
» using modern information and communication technologies (operational goal 7.2.3),
» improving patient safety and health literacy in the population – in particular in relation to information and communication – and measuring this as a matter of course (strategic goal 8.3.).

The rationale behind these links to several operational and strategic goals in the 2013 Health Reform is that processes of medical provision are, to a considerable extent, implemented via processes of communication (and face-to-face interaction in particular). In that respect, **quality communication is relevant to all strands of the Health Reform process.**

## Commission for the project group

Against this background, a project group on "Improving the quality of healthcare communication" was commissioned by the Committee on Public Health (FG PH/GF) to draw up this policy for all partners involved in the 2013 Health Reform. Its goal was *not* to develop and define concrete measures for implementation. Instead the goal of the policy is to provide content-based suggestions for promoting a culture and processes of quality healthcare communication, thus supporting the broad range of initiatives in this field.

# 2 What is good quality communication?

## 2.1 Fundamental orientation

In order to promote a culture of good quality healthcare communication on a broad basis, it is necessary for the various partners on different levels within the healthcare system to act in concert with each other. The traditional images of a paternalistic, illness-oriented model of medicine may have been criticized by many but they still influence the beliefs of patients, their relatives, health professionals, organizational matters and decision-making processes in relation to health policies.

This is why the following principles have been formulated as essential guidance for shaping communication processes. These principles focus on patient-centred medicine, patient autonomy and evidence-based healthcare.

1. **A fundamental alignment with the model of patient-centred health care**:
   Patient-centred interaction includes
   - » taking a somato-psychosocial perspective, which involves taking account of the interaction between physical, psychological and social factors,
   - » appreciating the significance of illness in the patients' lifeworld,
   - » an understanding of roles based on partnership, i.e. by supporting the patients' concerns, taking account of their need for information and their preferences when making decisions,
   - » factoring in the influence of the health professionals' personality and
   - » setting up and maintaining a therapeutic alliance, i.e. by developing therapeutic goals together and building up a relationship between health professional and patient.
2. **Communication as a key instrument in care, diagnosis and therapy**:
   Professional health care is acknowledged essentially as a communicative task with the aim of providing health education and appropriate guidance. Communication is an important component of care, diagnosis and therapy while patients are being treated. When health professionals communicate effectively, this has an important contribution to make to a successful diagnosis and to improving the state of health of patients (especially those who are chronically ill). Such consultations should only be delegated to clinical psychologists, psychiatrists or psychotherapists, etc. when there are specific indications to do so.
3. **Good communication can be taught and learnt**:
   Communication skills for clinical practice can be learnt and practised and everybody can improve them.
4. **Communication as a process which can be facilitated and guided in terms of its structure:**
   Because good communication can be taught and learnt, the quality of communication between health professionals and patients should not only be seen as a question of individual competence, talent and motivation, but requires guidance and facilitation by developing appropriate training measures and general frameworks.

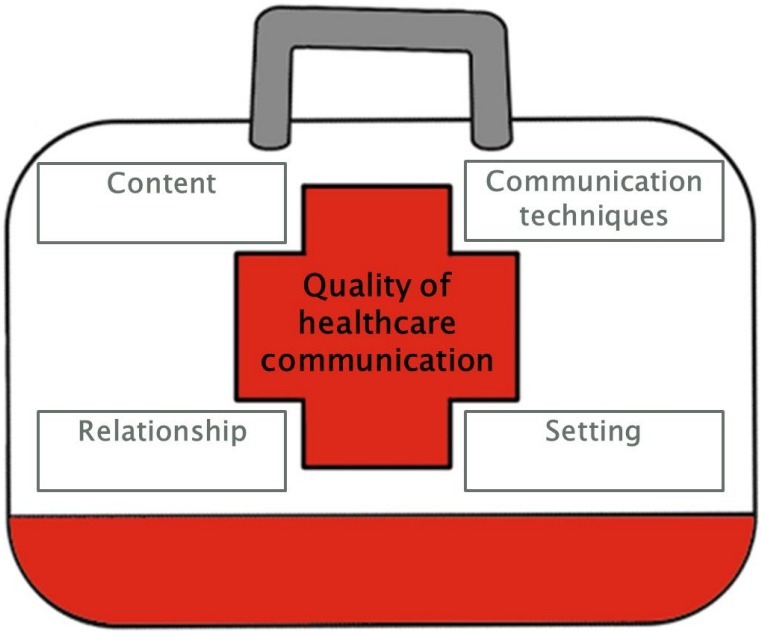
**Seen against the background of available evidence, good communication between health professionals and patients should not be seen as something negligible which is only "nice to have" but as an essential tool and effective intervention which can be taught and learnt, and which can be facilitated and guided in terms of its structure. Effective communication between health professionals and patients and/or their relatives should therefore be understood as an essential task and responsibility, to a much greater degree than has previously been the case, which would turn it into one of the most important resources in care, diagnosis and therapy.**

## 2.2 Dimensions of good quality communication

Good quality healthcare communication involves four main dimensions, all of which should serve as targets for future development initiatives:

» A linguistic-interactive dimension – communication techniques:
What verbal and non-verbal processes support the development of good communication?
» A content-related dimension – medical aspects:
Are clinically relevant contents discussed?
» A psychosocial dimension – relationships:
What approaches and attitudes contribute to relationships?
» The context in which the communication takes place – settings:
In which temporal, spatial and technical context does the communication take place?

Figure 2.1:
Four key dimensions of good quality healthcare communication




Source and illustration: GÖG

# 3 Why is good quality communication important? Expected outcomes from improving the quality of healthcare communication

Pertinent studies have demonstrated the benefits of improving the quality of healthcare communication: successful communication between doctors and patients, for example, is highly relevant in relation to health outcomes[4] such as

» the patients' **state of health**, e.g. in connection with diabetes, cancer, coronary heart disease, depression and the common cold,
» the patients' **health-related behaviour** (treatment adherence and the utilization of medical care, e.g. diagnostic tests and referrals),
» **patient satisfaction** and patients' **recommendations** of their doctors. On the whole it has become clear that patients' interaction with and relationship to their doctors as well as to health workers and nursing staff has the greatest influence on their overall satisfaction.
» **patient safety** (compromising patient safety e.g. in relation to delayed diagnosis or mismatched treatments) and the **frequency of lawsuits relating to medical malpractice**.

Furthermore, initial results suggest that poor communication skills in doctors also have negative effects on

» the health and job satisfaction of employees (high levels of burnout),
» the economic impact on patients, doctors and the entire healthcare system, e.g. due to the costs of legal disputes, the costs of unnecessary or unused treatments (e.g. medication, referrals) or costs caused by patients due to more frequent utilization of medical care when their emotional stress is not picked up on in consultations.[5]

In the meantime *inter*professional communication is also considered to be highly relevant as successful interprofessional communication contributes positively to employee motivation, patient participation, a reduction in drug use, patient safety and patient satisfaction.[6]

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4 For more detailed information cf. Sator et al. (2015a).

5 Ibid.; in addition the Committee on Public Health commissioned an evidence-based study which furnished wide-ranging proof of the economic impacts of improvements in the quality of communication, cf. http://evidenzberichte.goeg.at/?q=de/node/319

6 Ibid.

# 4 What is the status quo in Austria? Doctor-patient communication as an illustration

## 4.1 How good is the quality of communication in Austria?

Patient surveys on doctor-patient communication carried out throughout Europe, linguistic analyses and interviews with experts have revealed similar findings: **the quality of healthcare communication in Austria is below average within the EU.** Even though communication skills have become part of medical education programmes and are evaluated very highly in the literature, they should play an even more important role in everyday patient care. In Austria, too, patients' overall satisfaction correlates very highly with their satisfaction with healthcare communication. Experts have pointed out that the actual quality of doctor-patient communication varies greatly depending on the context, e.g. licensed doctors vs. those working in hospitals, private physicians vs. those accredited by a health insurance fund, communication between health workers/nursing staff and patients vs. doctor-patient communication. Vulnerable groups are affected particularly strongly by poor communication.[7]

## 4.2 What is the current status of initiatives in Austria?

On the whole, a large number of initiatives and practice models exist in Austria in relation to improving the quality of healthcare communication which would be relevant when drawing up concrete measures in this field.[8] Most of these depend on the commitment and motivation of individuals, however, and are often only of limited duration, meaning that there are virtually no systematic procedures nationwide to improve the quality of healthcare communication.

Not surprisingly, most of the measures which have already been introduced are within the healthcare system itself, followed by undergraduate/postgraduate/continuing medical education and research, with far fewer coming from politics, the media, the legal system and the business sector. These results indicate that, so far, measures to improve the quality of healthcare communication in Austria have hardly been applied to comprehensive frameworks or to the systematic development of a suitable culture and appropriate strategies. In addition, in the preliminary research report the Austrian measures were rated as not being sufficiently evidence based in comparison with international measures.

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7 For more detailed information cf. Sator et al. (2015a).

8 For more detailed information cf. Sator et al. (2015b).

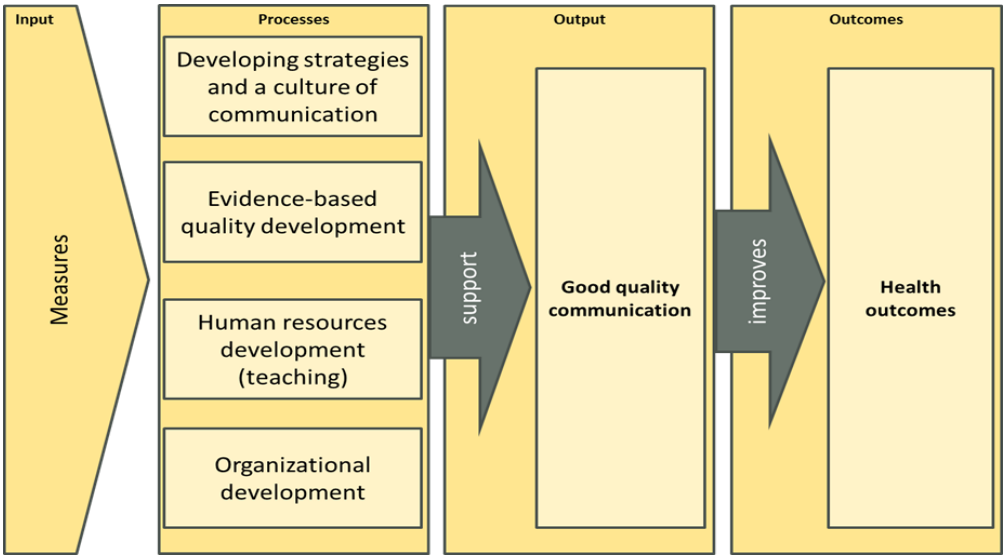
# 5 Strategic recommendations for action

The following strategic recommendations for action to improve the quality of healthcare communication proceed on the basis of an **intervention model** as borrowed from concepts in quality management: the overarching goal is to improve health outcomes. The quality of healthcare communication is a very important determinant of the desired quality of these outcomes. Factors which influence the quality of communication can be identified in the following **four fields of action**[9]:

1. the development of appropriate strategies and a culture of communication (policy)
2. evidence-based quality development
3. human resources development (teaching)
4. organizational development

On a national level, measures relating to the development of appropriate strategies and a culture of communication (policy) and evidence-based quality development programmes could boost the quality of healthcare communication. At the local/regional level of health professionals embedded in their organizational contexts, competent staff and beneficial conditions in healthcare organizations can improve the quality of healthcare communication. For these reasons, it is recommended that **measures** are applied in these four fields of action (cf. Fig. 5.1).

Figure 5.1:
Intervention model to improve the quality of healthcare communication




Source and illustration: Project Group on the Quality of Healthcare Communication

9
Based on the model of "Capacity Building & Awareness Raising" (http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Menu-for-CB-Actions_1.pdf) and the "Outcome Model for Health Promotion" (Nutbeam 1998) as well as the Swiss model for health promotion (Spencer et al. 2008)

The current **policy** is targeted at improving the quality of communication of **key health professionals** such as doctors, health workers, nursing staff and medical-technical staff in particular with patients (and/or their immediate family and relatives). In the first step, the **prioritized recommendations for action** focus **predominantly on face-to-face communication between doctors and patients** (and/or their immediate family and relatives). Alongside consultations for treatment, communication relating to the promotion of health and prevention are also covered. Many of the recommendations for action are just as applicable to **communication between patients and other health professionals**, in particular health workers, nursing staff, medical-technical staff, doctor's office receptionists, etc., although it is essential to take account of the differing communicative tasks typical for each occupational category.

In the context of this main focus, a series of related topics should be mentioned which are relevant in the context of an overall improvement in the quality of healthcare communication and which should also be taken account of when devising concrete measures for implementation:

» **communication between health professionals** (also interdisciplinary, interprofessional and between different organizations and sectors)
» **communication between patients as well as between patients and their social setting** (e.g. support groups)
» **mediated** communication processes (on the phone, in writing, using modern information and communication technologies, mass media)

Development needs and prioritized recommendations for action will be defined below for the four fields of action.

## 5.1 Field of action: development of appropriate strategies and a culture of communication (policy)

### 5.1.1 Development needs

This policy paper represents a first concerted effort to develop a culture of communication and communication processes at the level of the funding bodies. According to the experts questioned in the preliminary research phase, the stakeholders at the topmost level of the system have **no common understanding of the significance of the quality of healthcare communication or of introducing courses on communication skills to the undergraduate/postgraduate/continuing education of health professionals**. Even though communication skills have been included in such courses more often in recent years, their extent and quality differ greatly. There is still no nationwide consensus between the medical universities, professional interest groups and associations (Austrian Medical Chamber, Austrian Health Care and Nursing Association, etc.) and expert associations, neither on the relevance and teachability/learnability of good communication nor on how communication curricula could be introduced systematically and implemented in undergraduate/postgraduate/continuing medical education.

## 5.1.2 Prioritized recommendations for action

**Strategic public relations**

It is recommended that awareness of and familiarity with the significance of the quality of healthcare communication and with the policy on improving it should be increased in the medical community and elsewhere by publishing/presenting papers in relevant journals and at specialist conferences.

**Forming strategic alliances on effective communication with relevant partners**

On the basis of this policy paper, it is recommended that relevant partners (e.g. patient ombudsmen, professional interest groups, institutions offering undergraduate/postgraduate medical education, the Austrian Network of Health Promoting Hospitals) are contacted actively and encouraged to ensure that these institutions exploit all of the options to pick up on this issue strategically (e.g. specialist working groups on the topic of quality communication, covering the issue at conferences, networking with other relevant key players).

**Drawing up a consensus statement on the implementation of courses developing communication skills in the undergraduate/postgraduate/continuing medical education of health professionals and on their mandatory inclusion in the regulations for undergraduate/postgraduate medical education, lists of competences at different levels, curricula, examination regulations, etc..**

On the basis of this policy paper and international models, it is recommended that all stakeholders are invited to draw up a nationwide consensus statement and to pass resolutions on it in their decision-making bodies. It is suggested that the contents of the consensus statement are integrated step by step in the regulations for undergraduate/postgraduate medical education, lists of competences at different levels, integrated, interdisciplinary, interprofessional, longitudinal, multi-methodological communication curricula and examination regulations, etc..

**Establishing effective communication as a priority issue in the implementation of national policies and programmes**

It is recommended that

- the necessary legal foundations and funding concepts are passed, including incentive mechanisms, to improve the quality of healthcare communication,
- high quality communication is included as a priority issue in the implementation of national policies in the health sector (e.g. the action plan on women's health, the diabetes policy, the dementia policy, policies for patient safety),
- national, regional and local programmes on improving the quality of healthcare communication are initiated and supported,

» the topic of effective communication is taken into consideration in other programmes in the health system (e.g. telephone- and web-based first contact and advisory services (TEWEB), new primary care, integrated medical care programmes for the chronically ill),
» the Health Reform partners and relevant stakeholders (medical education institutions for all healthcare professionals, universities of applied sciences, professional interest groups and expert associations, the management of healthcare institutions) are supported in their endeavours to introduce a policy in their own area of responsibility to improve the quality of healthcare communication,
» a standardized nationwide system monitoring the quality of communication is integrated in existing monitoring systems in the health sector.

## 5.2 Field of action: evidence-based quality development

### 5.2.1 Development needs

According to the experts consulted in the preliminary research phase, initiatives on quality development relating to the quality of communication are partly not sufficiently evidence based and partly not relevant enough to the specific challenges of everyday patient care. One top priority problem was identified as being the **varying quality of continuing education courses**: there are numerous small- and larger-scale institutions offering modules on doctor-patient interaction which vary greatly in their contents and training methods. In addition, they draw on models and techniques of communication that can be evaluated in very different ways in relation whether they take account of differing communicative demands in different specialist areas and situations, the extent to which they have been fine-tuned with the challenges of everyday patient care and how evidence-based they are (practical implementation, expert consensus, evidence-informed studies).

Another very important problem is that **doctor-patient communication has still not been recognized as a starting point for a reasonable, evidence-based use of resources**. The increasingly technological nature of medicine and the deceptive conclusion that more medicine leads to more health both lead to unnecessary and sometimes harmful tests and treatment in the health sector and, consequently, to resources being wasted and it potentially no longer being possible to finance the health system. Purposeful doctor-patient interaction is required, facilitating the appropriate use of resources while involving those who are affected in the decision-making process.

## 5.2.2 Prioritized recommendations for action

**Drawing up evidence-based quality standards**[10]

It is recommended that

1. on the basis of international specialist literature, evidence-based **communication guidelines** (*what to teach*) are drawn up for
- » different communicative requirements such as risk communication and information on options for treatment (including the option of not providing medical treatment when inaction is the better choice) including taking account of the fact that there could be an increased need for communication in such cases[11],
- » different occupational categories, specialist fields and situations as well as
- » different target groups (also in order to ensure equality in health care, particularly for vulnerable groups);

2. on the basis of international specialist literature, evidence-based **teaching methodology guidelines** are drawn up on measures for undergraduate/postgraduate medical education relating to communication skills (*how to teach*) and these can also be introduced as quality standards for evaluating continuing education courses so that they
- » cover content-related medical and communicative dimensions,
- » do not only deal with techniques but also attitudes and
- » are specifically tailored to the challenges of everyday patient care.

**Drawing up exemplary training concepts for continuing education courses on communication skills on the basis of quality standards**

- » developing exemplary training concepts on the basis of quality standards
- » developing exemplary train-the-trainer programmes leading to qualifications for teaching staff on the basis of quality standards

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The concept of quality standards should be understood in a broad sense here and **not** in the narrow sense of "federal quality standards" (in accordance with the Act on Health Care Quality).

11

A point of orientation here could be the "Choosing Wisely®" initiative against unnecessary and sometimes harmful tests and treatment in the health sector: medical associations publish evidence-based lists of diagnostic and therapeutic recommendations for action in the varying specialist fields for which insufficient evidence is available or for which there is an unreasonable relationship between the potential benefits and risks of an expensive course of treatment. These lists should help doctors and patients discuss the appropriateness of specific diagnostic and therapeutic measures on a case-to-case basis.

**Ensuring the quality of continuing education courses**

It is recommended that the implementation of and adherence to quality standards relating to contents and teaching methodology in continuing education courses are guaranteed with the help of appropriate measures.

**Designing effective patient information leaflets and decision aids**

It is recommended that patient information leaflets and decision aids are designed with reference to evidence-informed studies and should increasingly exploit the potential of digitally aided health education by making use of new information and communication technologies (e.g. tablet, web or app-based support). In addition, the use of analogue aids should increase for passing on information such as images and texts in larger fonts in all important languages. In relation to common scenarios for chronic illnesses (especially cardiovascular disease), tools should be used to help assess risks and make use of risk communication.

## 5.3 Field of action: Human resources development (teaching)

### 5.3.1 Development needs

The **gap between theory and practice** was identified as a top priority problem in the field of undergraduate/postgraduate/continuing medical education: there is a clear rift between high quality medical education and unsatisfying possibilities for implementing what has been learnt in everyday patient care. Although communication skills have increasingly become part of the education programmes of healthcare professionals, their implementation in everyday patient care often lags behind these educational advances. Motivated health professionals often experience high quality communication with patients as being something which is "nice to have" but which is not highly esteemed in everyday practice and as a result they often become demotivated and frustrated in this respect.

### 5.3.2 Prioritized recommendations for action

**Upgrading the qualifications of senior health professionals and undergraduate teaching staff**

In order to guarantee the quality of the communication modules which are part of practical training, firstly it is imperative to convince senior health professionals of the importance of communication with patients and, if needs be, upgrade the qualifications of *senior* health professionals in teaching hospitals and clinics in relation to the quality of healthcare communication. Secondly the qualifications of health professionals working as *trainers* need to be upgraded in relation to the quality of healthcare communication (train the trainer), both subject-wise and in connection with

teaching methodology with the help of standardized curricula. As part of this recommendation for action, it is particularly important to improve awareness of the fact that communicating successfully with patients is a key professional tool which has an essential contribution to make to health outcomes. As an intervention it can be both taught and learnt. Teaching and assessing effective communication skills should be understood as an essential task and responsibility and as such as an indispensable feature of the organizational culture of healthcare institutions. Senior doctors, health workers, nursing staff and medical-technical staff should also act as role models in terms of the effectiveness of their communication skills in their everyday professional lives.

### Providing additional qualifications for teaching staff in continuing education

In order to guarantee the quality of continuing education modules, it is recommended that teaching staff acquire additional qualifications in relation to effective communication (train the trainer).

### Launching continuing education initiatives

It is recommended that practising doctors, health workers, nursing staff and medical-technical staff should undergo continuing education in professional communication skills. In view of the fact that so far continuing education courses for doctors have been paid for either by the doctors themselves or by pharmaceutical companies, it is recommended that existing and/or new funds should be combined and earmarked for the purpose, thus creating incentive mechanisms to take part in specialist continuing education courses.

### Running evidence-based patient education programmes

Patient education programmes and peer-to-peer/support groups should promote an understanding of the patients' own illness and their understanding of patient autonomy in relation to their own health, thereby helping them to take on the role of informed players and to employ their own resources to the benefit of their own health. It is recommended that more resources are invested in health education measures for vulnerable groups, particularly for migrants and asylum seekers, and the chronically ill, such as those with diabetes.

## 5.4 Field of action: organizational development

### 5.4.1 Development needs

According to the experts interviewed in the preliminary research phase, there are **organizational factors in the healthcare system and its institutions which impede** good quality communication in the everyday practice of health professionals.

### 5.4.2 Prioritized recommendations for action

**Incorporating effective communication in organizational terms**

It is recommended that the culture and practice of communication should be developed step by step in day-to-day routines and that importance should be placed on creating an atmosphere which facilitates good communication between patients and health professionals. It is advised that effective communication should be an explicit goal within intramural and extramural organizations. In order to achieve this, decisions must be made by senior staff members and individuals must be nominated to take on responsibility for it; appropriate measures must be included in internal staff policy and staff training plans; incentive mechanisms must be implemented to encourage participation in training modules and to improve the quality of healthcare communication (e.g. awards for employees who are particularly committed, encouragement in the form of specific training schemes offered by professional interest groups); funds must be made available and the quality of communication must be assessed as part of quality management (including patient surveys).

**Reorganizing the parameters for everyday communication and communication training as well as for assessing communication skills in practical training**

To ensure that health professionals doing their practical training witness good communication being given the weight it deserves in educational establishments and enough time being dedicated to it, appropriate value management is necessary as well as reasonable working conditions for employees, e.g. by identifying and reducing unnecessary tasks and by passing on tasks which do not have to be carried out by doctors within an interprofessional team (especially to administrative and nursing staff). In addition, it is recommended that structures and processes are created in teaching hospitals and clinics to implement good quality communication training and assessment of participants' communication skills.

**Systematic support for educational establishments responsible for implementing communication modules in practical training**

When medical training was reformed, the practical part was changed; by aligning it with international standards, structures were created which, amongst other things, can facilitate increased integration of social and communication skills in the practical training. Teaching hospitals and clinics are now facing the challenge of implementing those reforms with only limited resources at their disposal. In order to ensure successful implementation of high quality systematic and compulsory communication modules and (formative) assessment of those communication skills in practical training, it is recommended that the teaching hospitals and clinics are provided with systematic support – in the form of an implementation programme, for example – including organizational advice and supervision.

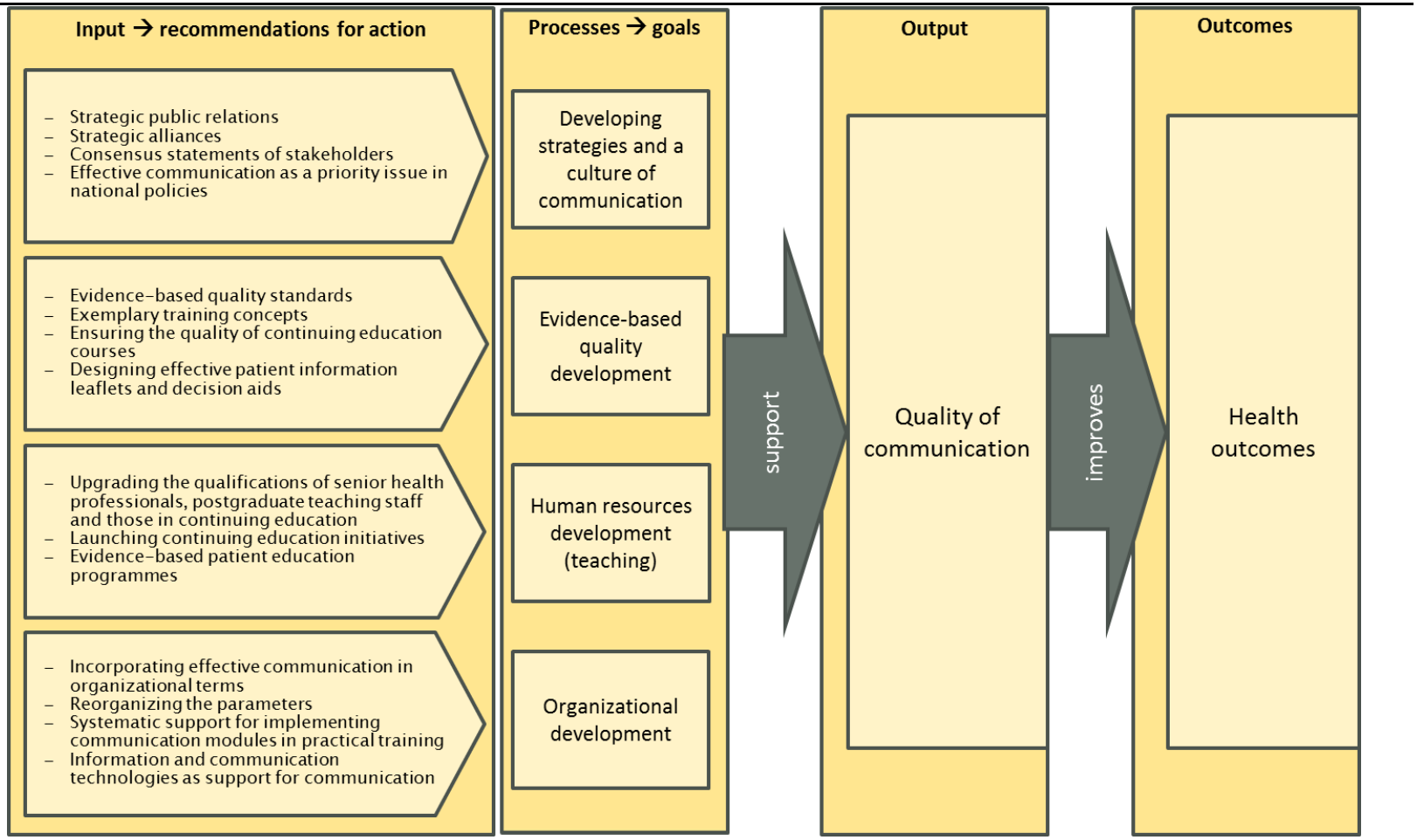
**Using information and communication technologies (ICT) as support for communication between health professionals and patients and not as a replacement**

When using new information and communication technologies and providing training on their use, alongside technical matters in connection with the use of such technologies, it should not be forgotten that ICT should only be used to complement face-to-face communication and not to replace it.

## 5.5 Diagrammatic overview of the priority recommendations for action

The diagram below **summarizes** the priority recommendations for action to improve the quality of healthcare communication in the four fields of action (cf. Fig. 5.2).

Figure 5.2:
Priority recommendations for action in four fields to improve the quality of healthcare communication

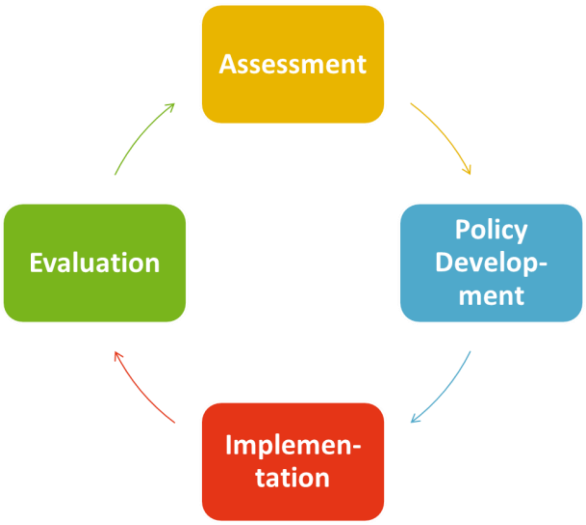



Source and illustration: Project Group on the Quality of Healthcare Communication

# 6 Further stages of implementation

The policy at hand on "Improving the quality of healthcare communication" should not be a static instrument but a dynamic one in the sense of a Public Health Action Cycle (Fig. 6.1). The planned process of implementation as laid down in the 2013 Health Reform (B-ZV, Part A, Art. 3) should also lead to a continuous process of optimizing the health system, to further improvements in the quality of health care, increased patient autonomy and closer orientation towards the population as a whole as well as patients and everybody employed in the health system.

Figure 6.1:
Public Health Action Cycle




Source: "Gesundheitspolitischer Aktionszyklus" (Rosenbrock 1995) from BZgA: Leitbegriffe der Gesundheitsförderung 2010

In this respect, the Federal Annual Work Programme for 2016 (operational goal 8.3.2.; measure 2) already stipulated that the step-by-step implementation of this policy should begin in 2016 with the involvement of the Austrian Platform for Health Literacy and the relevant committees on Public Health and Quality.

It can be assumed that the process of successfully implementing the measures in the four fields of action outlined above will take several years and that it can be sustained in the long term by **embedding an "engine for change" in existing structures**. With support from the committees on Quality and Public Health, an appropriate structure set up within the Austrian Platform for Health Literacy could initiate the next steps in the implementation process. Giving the Platform the role of coordinating this can be justified by the fact that implementing this policy will have a major contribution to make to realizing Outcome Objective 1 "Improving health literacy in the healthcare system by involving all the parties concerned" in Health Target 3. The main task of the Platform would be to initiate a broad-based dissemination of the contents of the policy and ensure that it is

discussed in the relevant circles. As implementing the policy of improving the quality of healthcare communication is also beneficial for the 2013 Health Reform and is intended to drive forward healthcare developments in Austria, it will definitely require sustained support from the Federal Health Agency and all Health Reform partners.

Once this policy has been adopted, the first step involves its **dissemination and communication** on a broad basis to all Health Reform partners and the most important stakeholders (medical education institutions for all healthcare professionals, hospital authorities, professional interest groups, patient advocacy groups, etc.) in order to initiate its implementation. A public presentation (e.g. at the Austrian Platform for Health Literacy's annual conference) should illustrate the significance of good communication in relation to health policy. In addition, presentations should planned in specialist media and at specialist conferences attended by stakeholders, accompanied by public relations work to gain the support of the stakeholders and the general public (cf. Section 5.1.2). Dissemination of and communication about the policy and its fundamental orientation (cf. Ch. 2) will also make an important contribution to re-orienting health care towards a culture of communication.

As the policy includes a broad range of recommendations for action, their implementation should be **prioritized along a timeline**:

1. For evidence based quality development , evidence based communication and teaching methodology guidelines are needed (cf. Section 5.2.2).
2. For the development of strategies and a culture of communication as well as undergraduate/postgraduate/continuing medical education (cf. Sections 5.1.2 and 5.3.2) the main priorities are:
    a. a **nationwide consensus statement on implementing the development of communication skills in the undergraduate/postgraduate/continuing education of health professionals** (and, if necessary, on context factors for effective healthcare communication) within and between the stakeholder institutions,
    b. the systematic **implementation** of the contents of this consensus statement in **lists of competences at different levels, curricula, examination regulations**, etc.
    c. **upgrading the qualifications of senior health professionals and teaching staff both at undergraduate level and in continuing education (train the trainer)**,
    d. diversifying the range of **evidence-based patient education programmes** as well as beneficial parameters for **peer-to-peer and support groups**.
3. For organizational development (cf. Section 5.4.2) it is recommended that the quality of communication is assessed as part of quality management on the one hand and that **measures to improve the quality of healthcare communication in practical training and in day-to-day routines are pilot tested** on the other. These pilot projects should be evaluated and experiences gathered in the implementation phase should be taken account of in the nationwide rollout.

**This project group was explicitly *not* commissioned to develop and define concrete measures for implementation. The prioritized recommendations for action should therefore be turned into concrete measures step by step, once this policy has been adopted and in close cooperation with the**

**relevant stakeholders (medical education institutions for all healthcare professionals, hospital authorities, professional interest groups and expert associations, patient advocacy groups, etc.). In doing so the accountabilities, responsibilities and consequences of the policy for the system partners (federal government, provincial governments, social security institutions) have to be made explicit in relation to finances, chronology and personnel. In order to realize concrete measures for implementation with the relevant stakeholders, special project-based funding will be necessary which can only be planned after close consultation with the stakeholders.**

In accordance with the Public Health Action Cycle (cf. Fig. Figure 6.1), alongside an evaluation of the prioritized measures for implementation, it is vital that the **overall effects** of the policy should be **assessed**. Here advantage can be taken of current monitoring programmes relating to the health target and of a *patient survey across several sectors*. Likewise, an Austrian-wide (and international) Health Literacy Survey which is being planned and prepared at present can give useful feedback on its reception in the general population.

# 7 Selected literature

## 7.1 Preliminary research for the policy

BMG (2014): Rahmen-Gesundheitsziel 3: Gesundheitskompetenz der Bevölkerung stärken. Bericht der Arbeitsgruppe. Bundesministerium für Gesundheit, Wien

Bundes-Zielsteuerungsvertrag (2013): Bundes-Zielsteuerungsvertrag Zielsteuerung-Gesundheit

Sator, Marlene; Nowak, Peter; Menz, Florian (2015a): Verbesserung der Gesprächsqualität in der Krankenversorgung. Grundlagen, Analyse und erste Umsetzungsempfehlungen für eine langfristige Weiterentwicklung in Österreich. Gesundheit Österreich GmbH, Wien

Sator, Marlene; Nowak, Peter; Menz, Florian (2015b): Verbesserung der Gesprächsqualität in der Krankenversorgung. Praxismodelle und Entwicklungsinitiativen. Gesundheit Österreich GmbH, Wien

Sator, Marlene; Nowak, Peter; Menz, Florian (2015c): Improving the quality of healthcare communication. Summary of preliminary research carried out for the Federal Ministry of Health and the Main Association of Austrian Social Security Institutions. [Verbesserung der Gesprächsqualität in der Krankenversorgung. Kurzbericht auf Basis der Grundlagenarbeiten für das Bundesministerium für Gesundheit und den Hauptverband der österreichischen Sozialversicherungsträger]. Gesundheit Österreich GmbH, Wien

## 7.2 What is good quality communication?

Balint, Michael (1957): The Doctor, His Patient and the Illness. Pitman: New York: International Universities Press, London

Mead, Nicola; Bower, Peter (2000): Patient-centredness: a conceptual framework and review of empirical literature. In: Social Science & Medicine 51/1087-1110

Menz, Florian; Sator, Marlene (2011): Kommunikationstypologien des Handlungsbereiches Medizin. In: Textsorten, Handlungsmuster, Oberflächen Linguistische Typologien der Kommunikation. Ed. Habscheid, Stephan. de Gruyter Lexikon, Berlin, Boston: 414-436

Nowak, Peter (2015): Leitlinien für das Arzt-Patienten-Gespräch - sinnvolle Hilfestellung für den ärztlichen Alltag? In: Handbuchreihe "Sprache und Wissen". Eds. Busch, Albert; Spranz-Fogasy, Thomas. de Gruyter

Stewart, M. A. (1995): Effective physician-patient communication and health outcomes: A review. 152, Canadian Medical Association Journal 1423-1433.

## 7.3 Why is good quality communication important? Expected outcomes from improving the quality of communication

Brown, R. F.; Butow, P.; Dunn, S. M.; Tattersall, M. H. N. (2001): Promoting patient participation and shortening cancer consultations: a randomised trial. In: British Journal of Cancer 1273

Chen, R. C.; Clark, J. A.; Manola, J.; Talcott, J. A. (2008): Treatment 'mismatch' in early prostate cancer: do treatment choices take patient quality of life into account? In: Cancer 112/1:61-68

Loh, Andreas; Leonhart, Rainer; Wills, Celia E.; Simon, Daniela; Härter, Martin (2007): The impact of patient participation on adherence and clinical outcome in primary care of depression. In: Patient Education and Counseling 65/1:69-78

Stahl, Katja; Nadj-Kittler, Maria (2013): Zentrale Faktoren der Patienten- und Mitarbeiterzufriedenheit. Picker Institut Deutschland GmbH, Hamburg

Street, Richard L.; Cox, Vanessa; Kallen, Michael A.; Suarez-Almazor, Maria E. (2012): Exploring communication pathways to better health: Clinician communication of expectations for acupuncture effectiveness. In: Patient Education and Counseling 89/2:245-251

Tamblyn, R.; Abrahamowicz, M.; Dauphinee, D.; et al. (2007): Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. In: JAMA 298/9:993-1001

## 7.4 What is the status quo in Austria?

HLS-EU Consortium (2012): Comparative Report of Health Literacy in Eight EU Member States. The European Health Literacy Survey HLS-EU. The international Consortium of the HLS-EU Project

## 7.5 Strategic recommendations for action

“Capacity Building & Awareness Raising” (http://eurohealthnet.eu/sites/eurohealthnet.eu/files/publications/Menu-for-CB-Actions_1.pdf)

Nutbeam, D. (1998). Evaluating health promotion - progress, problems and solutions. Health Promot Int 1998;13(1):27-44

Spencer B, Broesskamp-Stone U, Ruckstuhl B, Ackermann G, Spoerri A, Cloetta B. (2008). Modelling the results of health promotion activities in Switzerland: development of the

Swiss Model for Outcome Classification in Health Promotion and Prevention. Health Promot Int, 23(1):86-97

## 7.6 Further stages of implementation

Bundes-Jahresarbeitsprogramm (BJAP) 2016 zur Umsetzung des Bundes-Zielsteuerungsvertrages auf Bundesebene. Beschlossen am 28.9.2015 durch die Bundes-Zielsteuerungskommission.

Gesundheitspolitischer Aktionszyklus (Rosenbrock 1995) aus BZgA: Leitbegriffe der Gesundheitsförderung 2010