

# A New Communication Course for Junior Doctors

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## Abstract

This article gives an overview of a new communication course for junior doctors. Needs-based Communication (NBC) addresses the key Foundation competencies of communication with patients, working with colleagues, and professional behaviour. The NBC approach is unusual for its emphasis not just on patients' needs, but on the needs of healthcare professionals themselves. One objective is to raise awareness of whose needs we choose to address at any particular moment, and how this awareness (or lack of it) plays an essential role in the development of interpersonal relations.

Since 2005, 49 two-day NBC courses have been delivered to a total of 653 junior doctors in two Foundation Schools (South Yorkshire and South Humber, and Trent). This paper provides a description of the NBC model used on the course, examples of the contexts in which it can be applied, and an overview of the course content. The NBC model is also compared and contrasted with the existing Calgary-Cambridge approach.

557 doctors completed the end-of-course evaluation form. On a ten-point scale, the self-perceived level of communication skills increased from a mean of 4.2 before the course to 8.1 afterwards; while the doctors assessed the usefulness of the course at work, the quality of training and recommendation of the course to others at 7.7, 8.5 and 9.4 respectively.

NBC introduces a framework in which communication has the potential for skills development in different contexts by health professionals. The course deserves wider consideration in view of the positive evaluations.

## Introduction

Communication lies at the interface between what happens 'in here' – in our own world of intentions, responses, diagnoses, decisions, and everything that leads to action – and what happens 'out there' in the world about us as we interact with it. It is a means of translating our internal responses in such a way that others in our external environment can understand and act upon them. To be effective, a course on communication for doctors needs to explore these processes in a way that is practical enough to use within a clinical setting, and yet complex enough to do justice to the demands of a situation where the internal and external factors must be balanced, usually under pressure of time.

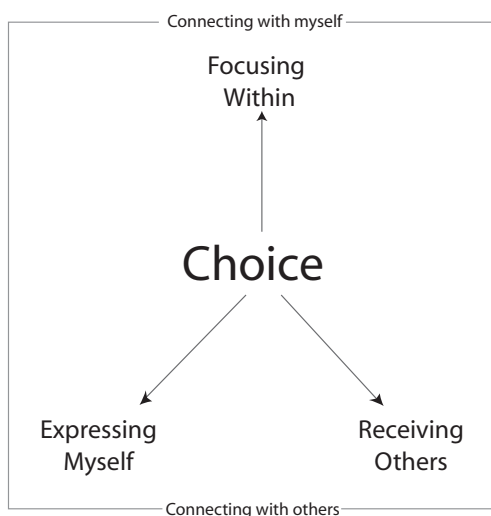
This article gives an overview of a communication course which aims to do just this. The course is based on an internationally recognised model known as Nonviolent Communication™, devised by clinical psychologist, Dr. Marshall Rosenberg.<sup>3</sup> This has been applied within healthcare in the United States and elsewhere, and has already received some attention within the medical establishment in the UK.<sup>4</sup> We have amended the name of the process to Needs-based Communication (NBC), with the aim of emphasising the key concept behind the model. Since 2005, 49 two-day NBC courses have been delivered to a total of

653 junior doctors in two Foundation Schools (South Yorkshire and South Humber, and Trent). The course addresses the key Foundation competencies of communication with patients, working with colleagues, and professional behaviour.<sup>5</sup> In order to highlight the objectives, one Foundation School uses the course title ‘Dealing with Conflicts and Complaints’, while the other chose ‘Building Respectful Relationships with Patients and Colleagues.’ These titles also distinguish the course from the well-known Calgary-Cambridge consultation model, which is used in many undergraduate curricula and primary care settings.

This paper provides a description of the NBC model used on the course, examples of the contexts in which it can be applied, and an overview of the course content. We end with a comparison of NBC with the Calgary-Cambridge approach, and a summary of evaluations completed by doctors at the end of the course.

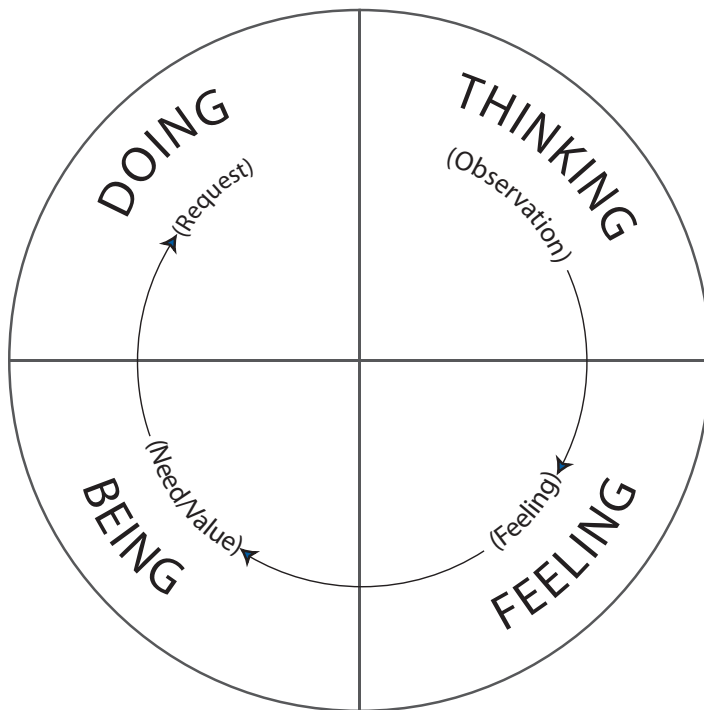
### The Needs-based Communication (NBC) Model

The needs-based approach is unusual for its emphasis not just on patients’ needs, but on the needs of healthcare professionals themselves. Naturally, doctors’ professional needs often coincide with those experienced by a patient or colleague (for example, for quality patient care, efficiency, clarity, honesty, keeping agreements, etc.), and it is these that form the bedrock for their professional decisions. One objective of the course is to raise awareness of whose needs we choose to address at any particular moment, and how this awareness (or lack of it) plays an essential role in the development of interpersonal relations. Raising doctors’ awareness of where they focus their attention gives them a greater sense of choice about when and how they interact.<sup>3</sup> (pp.3-4) In Figure 1, we summarise the choices as follows: (a) ‘Focusing Within’ to look at the issues that need attention within ourselves (which we may do alone, or by talking them through with somebody else), (b) ‘Expressing’ by voicing our concerns directly to the other person/people involved, or (c) ‘Receiving’ in the sense of engaging with the issues that are arising for the other person/people. Within a particular interaction we may, of course, do all three.



**Fig. 1:**  
**Choices in Communication**

Knowing where to place our attention helps to achieve the intention implicit in communication, namely, to connect in a useful and/or meaningful way with another person. The course therefore focuses on the concept of connection, aiming to increase doctors' understanding of how connection may be formed or lost within an interaction. Focusing upon the principles which underpin connection avoids a prescriptive or formulaic approach to communication, and helps build on doctors' existing strengths. These principles are explored under four broad headings: Thinking, Feeling, Being, and Doing, as shown in Figure 2.



**Fig. 2:**  
**Principles of Communication**  
(The inner circle indicates a framework for communication, as discussed below.)

‘Thinking’ refers to our perception of our specific context at any one moment, and includes two kinds of ‘thinking’<sup>3</sup> (pp.26-35):

- a ‘clean’ perception / observation of facts determined by sensory input (what we see, hear, etc.);
- our evaluation, analysis, judgement, or interpretation of those facts.

‘Feeling’ refers to the psycho-physical / emotional responses we have to the context, triggered externally by what we observe or interpret<sup>6</sup>, and internally by our own past experiences, and the ability to comprehend the breadth of a situation somatically.<sup>7</sup>

‘Being’ refers to the shared, universal needs and values that we hold as living beings, seen here as the internal cause of our feelings (broadly, we feel ‘ok’ when needs are met, and ‘not ok’ when needs are not met).<sup>8</sup>

‘Doing’ refers to our actions, behaviours, strategies, solutions and requests that reflect our response to the above (i.e. our context and its effect upon us).<sup>9</sup>

Looking in more depth at this model, doctors are asked to consider:

- the difference between objective observation / description of facts, from subjective evaluation and judgement;

- the function of feelings as a useful indicator, that is, as helpful information which tells us whether a need is met or unmet – much as in medicine, pain is information pointing to a deeper cause.<sup>3</sup> (pp. 41-3; 49-66; 141-4) This approach does not suggest that feelings need to be voiced –often difficult ground for patients and professionals<sup>10</sup>– but offers a way to understand and deal with emotions when they are running high, either within oneself, or in people around us;
- the interconnectedness of our needs and values as human beings, and hence our ability to relate to other people on the basis of those universal experiences;
- the fact that actions and behaviours are expressions of – indeed strategies for fulfilling – our needs and values.

The last two points indicate a distinction between a ‘need/value’ and the strategy or action which may meet or fulfil it. The word ‘need’ is here used in the very particular sense of a universal value, an essential quality, or shared concern, as in the examples given above, e.g. honesty, openness, efficiency, team-work, collaboration, etc.<sup>3</sup> (54-5; 214) (This usage is close to the concept of needs defined by Maslow, although more in line with a non-hierarchical exposition of needs as responses to, and arising from, conditions, such as that described by Max-Neef<sup>11</sup>). Rosenberg’s contribution is to point out how in communication we tend to confuse our ‘needs’ (as defined here), and our strategies.<sup>3</sup> (73-4) This confusion is unsurprising as the word ‘need’ does often point to an action. For example, the strategy, ‘I need you to work an extra shift this week’, may actually point to an underlying ‘need’ for – depending on context –support, or efficient use of resources, or teamwork. While we may clash on the strategy suggested (that I should work more shifts this week), we can both resonate and agree on the level of the genuine needs, because they are held in common. Thus conflict happens only on the level of strategy, because even if needs are different, it is always possible to understand and relate to each others’ needs and values, which are by definition universal (in this example, your need may be support, mine may be for rest). Having established what our needs are, it is then possible to explore different strategies and outcomes to meet those needs; ideally, ones capable of meeting/acknowledging the needs of both concerned.

What may get in the way of relating to somebody else’s needs is a judgement of that person as in some way at fault – views which are often the cause of disagreement.<sup>3</sup> (pp.15-24); 9 (p.12) Here, the distinction between a need and strategy is once again useful for reducing and resolving conflict. The course explores how the behaviour of someone labelled as (say) an ‘aggressive’ colleague, or an ‘annoying’ relative can be seen as an expression of that person’s unmet need. Confused, and ultimately unsuccessful as their behaviour may be in meeting their own needs, it may be the only expression of their unmet need they have available to them at that moment in time. As Rosenberg puts it, such behaviours are “tragic expressions” of the person’s own unmet needs.<sup>12</sup>

The idea that offensive behaviour or blaming language may be the strategy someone is using to express their unmet needs immediately opens up more creative and empathic ways of dealing with the person involved. Thus, while I may not be willing to countenance their unhelpful behaviours (their ‘strategies’), I can, as another human being, resonate with the

needs/values that underpin it. What is more, once I can identify their needs, I may be able to help that individual find other, less harmful, strategies to meet them – solutions which are also able to take into account my needs, and those of other people involved.<sup>13</sup>

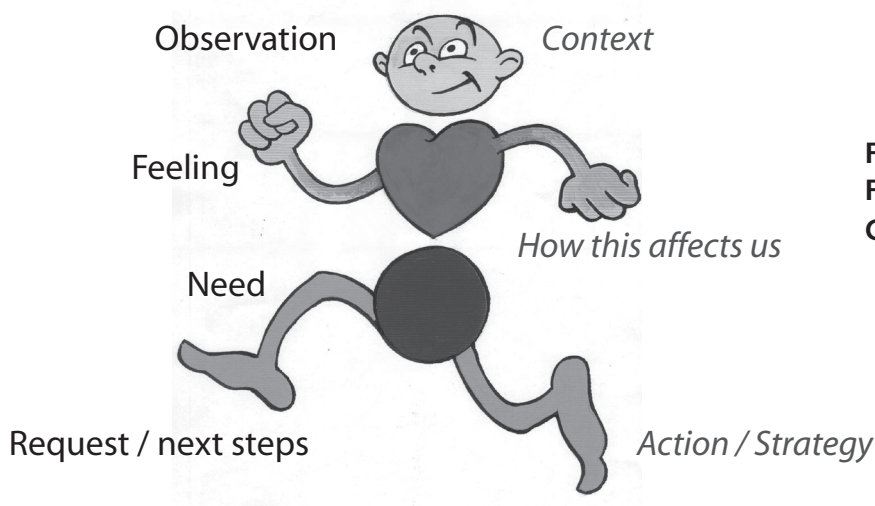
In summary, what this course offers doctors is a form of communication that encourages connection and avoids harmful disconnection. On the one hand, doctors learn how to express what is going on for them in a way that avoids making subjective evaluations and judgements of themselves or others – realising as they do so how such expressions often say more about their own unmet needs than they do about the other person.<sup>3</sup> (pp. 129-40) On the other hand, doctors learn how to receive another person in such a way that they focus upon that person's underlying concerns (their feelings and needs). They are therefore increasingly able to understand any judgemental language or 'difficult' behaviour as an attempt to express those needs.

### Applying the NBC Model to Communication

The needs-based process applies the principles of connection within a framework that mirrors the natural sequence of communication when communication is going well (as shown on the inner circle in Fig 2). Thus<sup>3</sup> (pp. 6-8):

- We observe the context, or the 'trigger' for a situation, based on describable facts;
- We understand how that context is affecting me/another; that is, the feelings and underlying needs or values it brings to life, which supplies the rationale for the action that follows;
- We seek the best strategy, given that information.

The model is more fluid than it may look here in written form. After all, if one is in good connection already with another person, it may be enough to simply express one's request, without mentioning either the context, or the reason behind it (i.e. how one is affected / the need the request intends to fulfil). Nevertheless, the course demonstrates how often we 'short circuit' in our communication, missing out one or more of these principles, and sometimes giving out a very different message from the one we intended to send. Fig. 3 demonstrates how the model gives a complete picture of a person, creating the maximum chance of making a good connection with others, by showing clearly what is happening, how that affects people, and what action is wanted as a result.<sup>3</sup> (pp. 67-74; 81-9)



**Fig. 3:**  
**Framework for**  
**Communication**

This framework can be used to avoid conflict, and to reduce anger or aggression in a safe way.<sup>3</sup> (pp. 117-21; 141-59) In other words, the aim is to reduce or (ideally) remove one's own judgemental or blaming reactions to a situation—often a cause of conflict—and thus to keep a positive connection with the other person/people involved, while still giving an honest and complete picture of what is going on.<sup>3</sup> (pp. 175-9) The same model can apply whichever 'choice' one is making (as shown in Fig 1), that is, whether one is: (a) 'focusing within', in order to stay calm and take stock before deciding whether to speak, or what to say, (b) 'expressing'; being honest about one's own concerns without implying judgement and blame of the other person; and (c) 'receiving' the other person, so that they are fully heard and understood. Table 1 below shows an extract from a dialogue in which a doctor has been asked by a worried female nurse to speak to Mr Jones' relatives on her behalf. After a moment focusing within, the doctor decides to explore another option, and express:

**Table 1: Principles of connection for expressing**

<p>Context:</p> <p>Expressing the context as an observation, without evaluation</p>	<p><i>[Doctor addressing the nurse]</i> "Just now I'm late leaving my shift – and I remember finishing Mr. Jones' TTO's this morning, and thought he had been discharged already."</p>
<p>Letting the other person know this affects me:</p> <p><i>Owning my feelings and underlying needs</i></p>	<p>I'm feeling frustrated because it's important to me to keep the arrangements I made with my family today, and also concerned, because I want things to work efficiently and smoothly in the team.</p>
<p>Action:</p> <p>Suggesting a possible strategy, and taking the other person's needs into account.</p>	<p>Is there another way to resolve the problem without involving me right now? Have you got any other ideas that would give you the support you need?"</p>

Naturally, despite the doctor's attempt to connect with the nurse by expressing him/herself, a stressed nurse might well reply that there really isn't any other option but for the doctor to do as she's asking right away. At this point, the option of 'receiving' would be the best choice—and may in itself open up a productive dialogue. People are, after all, more likely to hear us once they have been heard themselves.<sup>14</sup> The doctor would then use the principles of connection to find out what is going on for the nurse by judiciously reflecting back what she says, allowing for the nurse to correct or alter what she means, if necessary. Thus the nurse's perspective of the situation would quickly emerge, along with a complete picture of her own feelings and needs, and a correct understanding of her desired strategy. This avoids hackneyed (and often unconvincing) phrases, such as "I understand what you

are saying, but...” and develops an increasingly effective and time-efficient way of defusing difficult situations.<sup>3</sup> (pp.74-6, 91-8, 100-1); 12 (pp.27-9) The doctor’s genuine effort to understand what is going on for the nurse, and how she is affected, is likely to open up her willingness to stand in the doctor’s shoes for a moment, and to accept a different outcome if the doctor is not able or willing to comply with her request. Of course, the doctor’s own perspective may change as well, hearing things more fully from the nurse’s point of view. This mutual understanding gives them an efficient tool for good teamwork, offering a way forward to agree a different strategy that would work for them both in this moment.

## Course Content

The course introduces needs-based communication through a close examination of the choices and principles that are involved in developing and maintaining positive connections with patients and colleagues, as discussed above. A variety of approaches are used in the teaching, including presentations, group discussions, pair-work, self-reflection and roleplays. Roleplays are experiential (rather than created by actors), as this gives doctors the chance not simply to practise concise expression and genuine empathy (as a doctor), but to experience first hand their effects (as a patient/relative/colleague), and to notice how empathy differs from its near relations, such as sympathy, education, explanation, advice, consoling etc.<sup>3</sup> (pp. 91-4) Empathy is thus developed as an essential skill for defusing and calming situations, and for dealing with angry, aggressive or upset people.<sup>6</sup> (pp. 77-85)

**Table 2: Summary of Course Content**

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*Expressing oneself (Day 1)*

- Making difficult requests of patients, relatives or colleagues;
  - Standing one’s ground when one is unsure, but wanting to maintain trust and respect;
  - Giving constructive feedback to colleagues and expressing appreciation genuinely;
  - Dealing with the effect of ‘difficult’ behaviours on oneself or others.
  - Apologising effectively for system/personal error.
- 

*Receiving others (Day 2)*

- Empathising with people who are distressed, annoyed, angry etc.;
  - Resolving conflicts, defusing and de-escalating situations;
  - Saying ‘no’ and negotiating outcomes most likely to meet the needs of those concerned;
  - Translating blaming and judgemental language into useful messages;
  - Interrupting skilfully to keep consultations focused;
  - Dealing with challenging behaviours and language in colleagues, patients and relatives.
-

## Comparison of NBC with Calgary-Cambridge (CC)

The course differs from the well-known Calgary-Cambridge (CC)<sup>15</sup> model in several ways.

- It takes a more generic approach to communication with patients, colleagues and teams, where CC focuses principally on the medical interview and consultation skills with patients;
- It looks at communication in a wide variety of contexts and situations, with a particular emphasis on calming and reducing anger, resolving difficulties and building trust;
- It has a simple three/four-fold framework in comparison to CC's (self-admittedly<sup>16</sup>) large and complex checklists;
- It works from principles, thereby encouraging doctors to make their communication individual and authentic, and avoiding any sense of prescription or 'technique';
- It is aimed at doctors with a broader base of experience 'in the job' (as one second year postgraduate doctor put it, who had appreciated her undergraduate training in CC, "the needs-based approach is more useful for now.")
- It focuses upon doctor's core values ('universal needs'), which are seen as the bedrock of interpersonal communication and development.

The final point highlights an interesting difference between the two approaches. In a recent article, Silverman distinguishes between skills-development using the CC model, and the cultivation of values/attitudes, and asks whether the CC guides have 'promoted skills at the expense of values, attitudes, and intentions'.<sup>16</sup> In the needs-based approach, the 'skill' is itself that of detecting the needs, values, attitudes or intentions of the various parties within a situation, and of either empathising with those in another, or of voicing them oneself. The primary focus of the course is how to do this in such a way as to create and develop a positive connection with the other person. The needs-based approach could also be described as a values-based, empathic, or compassionate approach. It is one that asks doctors to show their colours as caring people with a heart and soul. In this way, it is in tune with the zeitgeist<sup>17</sup> which requires doctors not just to be technically specialist and expert, but compassionate individuals capable of responding positively and appropriately to other people, whatever behaviour and language they may be using.

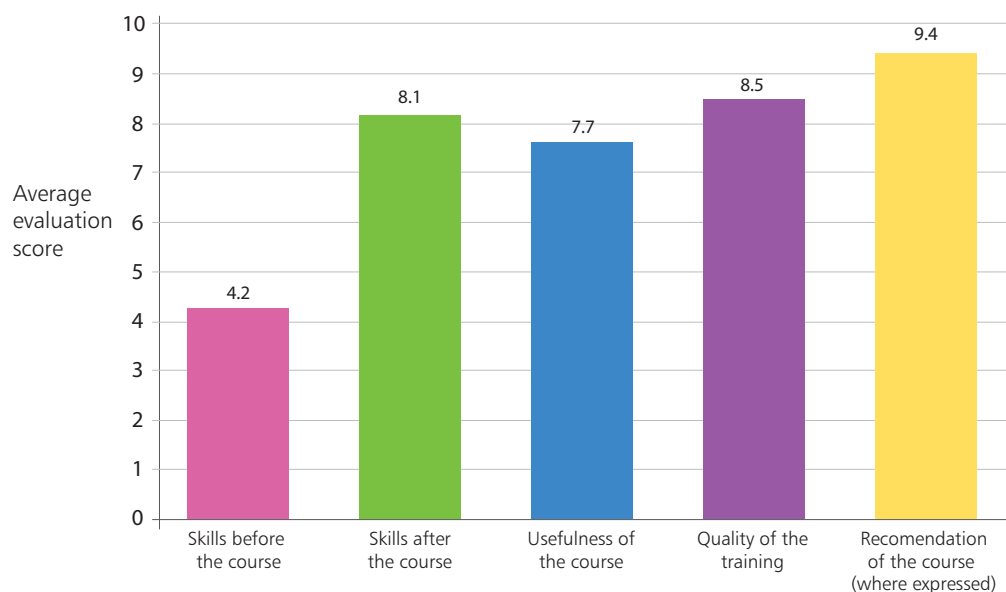
## Course Evaluation

Doctors were asked to evaluate the following aspects of the course on a scale of 0-10: level of communication skills before and after the course; usefulness of the model in professional situations; quality of the training; and whether they would recommend the course to others. Comments were also encouraged. Of the 653 doctors who attended the course, 557 presented complete evaluation forms. The bar chart in Figure 4 represents the means for these evaluations. A further analysis of the results by gender shows no significant differences. Of the open comments offered, 65 were unsure, 18 were negative and 457 were positive. Those doctors who were unsure focused principally on whether a communication course was the best use of time and resources for Foundation doctors, rather than improving clinical skills. They also pointed out that the new approaches were challenging

and needed practice. The negative comments questioned whether the model was applicable in medical settings, or showed a basic dislike for the approach itself; seeing it as either too simplistic or too complex. The positive comments appreciated the clear framework and structure the process gave to communication, highlighted the benefits of understanding other people's needs, and found helpful the idea that difficult or painful feelings are caused by underlying unmet needs. Verbally, doctors commented that the course supported their upcoming job interviews, and one doctor presented a written complaint that he had been unfairly disadvantaged by attending the course only after his interviews – prompting the Deanery to run all courses earlier in the Foundation Programme, before the interview period.

**Fig. 4:**  
**Self-Evaluations from three Foundation Programmes (2005-6, 2006-7, 2007-8)**

*Participants' assessment of their skills and learning*



## Conclusion

The NBC course has a wider remit than the existing Calgary-Cambridge model, and complements it in a number of ways. It covers the key competencies in the Foundation Curriculum, and introduces a framework in which communication has the potential for ongoing skills development in different contexts by health professionals. The initial self-evaluations are encouraging, but would gain from subsequent evaluation over time. While the skills learned need embedding with practice, the authors believe that the course itself deserves wider consideration given the positive response. Further information can be found on the Life at Work website.<sup>18</sup>

## Acknowledgements

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## Competing Interests

Elizabeth English is the Director of Life at Work and chief trainer/facilitator of the course. Jonathan Beard is a Foundation Training Programme Director.

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