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The key to good healthcare communication

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People communicate by virtue of their existence, however, the process, content and impact of their communication varies across situations. Communication serves different purposes, depending on the context in which it takes place.

Within the context of a healthcare visit, every word and gesture seems to have meaning. Healthcare providers, on one hand, have to rely on a patient's story to discover the reason for visit and to estimate the level of distress and concerns of the patient. Patients, on the other hand, have to absorb a flow of messages such as instructions, information and advises, which providers may pour out to them in a more or less understandable way. Apart from the content of the communication, the manner in which it is conveyed is equally important. Providers' attitude, interest and intention have shown to impact on patients' health [1]. Patients appear to benefit from information provided in an empathic and friendly way. The quality of the provider–patient communication has potential influence beyond that of the therapeutic intervention [2]. Yet, the choice for one therapeutic intervention over another is guided by evidence-based knowledge recorded in practice standards and guidelines.

Standardization of a communication process tailored to an individual patient with its own idiosyncratic needs and expectations is, however, inherently impossible. Nevertheless, researchers and trainers need methodological standards in the form of reliable and valid coding instruments which are able to capture the broad variety of communication behaviors within an encounter between a healthcare provider and a patient. Such coding schemes are necessary to explore and define the most effective communication strategies. A coding scheme can therefore be understood as the key to good healthcare communication.

The Roter Interaction Analysis System (RIAS) has been the most frequently utilized coding scheme since many decades [3]. In this issue of Patient Education and Counseling, several strengths and weaknesses of the RIAS are discussed in detail by Sandvik et al. [4]. In their contribution, Roter and Larson [5] comment on the issues put forward by Sandvik. These two papers are a good example of the value of bringing different expert opinions together concerning the validity of standardized coding systems of communication in different health care settings.

RIAS coding categories and definitions have been adapted to new insights and research purposes several times [3,6–8].

This evolution of the coding scheme mirrors the ongoing evolution of medical practice. After all, today's medical practice is governed by different paradigms than it was 20 years ago. Consequently, the concepts which are to be captured by a coding scheme should be amenable to change as well. In the field of healthcare communication, patientcentredness, shared decision-making, patient involvement, empowerment and consumerism are the prevailing concepts of the new century, concepts known for their multidimensionality and complexity. Dealing with these concepts can either be done by developing new instruments or by adapting existing ones. Roter et al. have shown that it is possible to use the same coding scheme within a changing context by constructing communication composites out of existing coding categories as measures for new concepts [9,10].

Despite, or may be as a result of this system's flexibility, the psychometric properties and content validity of the RIAS has repeatedly been questioned and criticized [11]. One of the major criticism has to do with the fact that no matter how valid a coding system is, it always produces an interpretation of actual medical practice. After all, we never can tell what goes on in the head of a patient, or what intentions the provider has when posing a certain question. Trying to reconstruct a communication process from the coded

communication categories will be impossible to do. This inevitable loss of information will take place regardless of the nature of the coding scheme.

Qualitative research is guided by other premises than quantitative research and therefore offers means to examine communication processes in a different way. This seems to be the basis for the controversy between the present contributions of Sandvik et al. [4] and Roter and Larson [5].

Most of the very interesting and important RIAS adjustments which have been suggested by Sandvik and colleagues are derived from concepts in linguistic interaction analysis which place more emphasis on meaning and turn-taking than more quantitative analysis methods. An accurate exploration of, for example the duration of interruptions, pauses and silences can be very meaningful as such. Yet, examining these communication aspects does, however, require more time than usually available in quantitative observation studies. Therefore, the purpose of a particular research project should determine the kind of coding scheme that should be used and not the other way around.

The RIAS has been used most frequently in dyadic physician–patient interactions. As actual healthcare practice comprises different forms of encounters, the RIAS should be made applicable to other settings, such as nursing or triadic interactions, in which the third party is the provider's colleague, the patient's partner or the patient's parent [12]. Besides, by stressing the importance of interaction, more effort should be put into examining communication sequences apart from solely relying on frequencies of communication behaviors. In our opinion, the RIAS forms a suitable basis as a coding scheme within a variety of healthcare settings. For the sake of comparability the main communication categories which are distinguished within the RIAS should be maintained. Nevertheless, to do justice to healthcare settings and disease-specific communication, the RIAS categories should be subdivided more or completed with a checklist containing disease-specific items.

The contribution of Sandvik et al. [4] gives numerous clues to broaden the applicability of the RIAS, but most of all, it points out that it is important to be open to alternative ways of measuring communication in different healthcare settings. It forces Roter and Larson [5] in this issue to reconsider the utility and flexibility of the RIAS. Researchers, educators and health care providers are invited to present their view at this discussion.

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