

## CASE STUDY AND LESSONS LEARNT

# Tailoring communication training for health care providers: a case study in translating research into practice

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## ABSTRACT

**Background:** Patient dissatisfaction and distrust in primary health care can negatively affect relations between patients and primary health care providers, which in turn affects health outcomes. Communication training for providers can be effective at improving provider–patient relations and improving health. However, gaining provider commitment to improving communication can be challenging, especially when the training content and approach are standardized and not tailored to the needs of providers and the local and contextual factors they face.

**Methods:** Through a needs assessment of both patients and providers, as well as continuous feedback throughout a communication training course for providers in Kazakhstan, tailored communication training materials were

developed that increased people-centredness in and addressed the specific needs of primary health care providers.

**Results:** Through (i) demonstrating to providers that their specific needs had been incorporated into the training course and (ii) framing the communication skills as tailored solutions to the challenges they face in treating patients in primary health care, communication training successfully overcame resistance in providers and increased their commitment to improve communication.

**Conclusion:** Once provider resistance is overcome, communication skills can be learned more effectively and are more likely to be put into practice.

**Keywords:** PROVIDER–PATIENT COMMUNICATION, BEHAVIOUR CHANGE, TRUST, COMMUNICATION TRAINING, KAZAKHSTAN

## BACKGROUND

Transitioning to a primary health care model requires changes to patient behaviour related to accessing care, acquiring health information and making informed health decisions outside the health system. Likewise, changes in primary health care providers are needed to support patients with new behaviours, knowledge and motivation through putting people at the centre of care. A shift towards people-centred care, including engaging patients and their families, carers and extended support groups (1), requires a shift in the relationship between the provider and the patient. How this shift is established depends on the ability of providers within the health system to effectively communicate their new roles, responsibilities and expectations. Communication that establishes a relationship of trust improves patient satisfaction, service utilization,

adherence to treatment and changes in health behaviours, which in turn improve health outcomes (2–5).

Communication skills can be learned by health care providers (6–9), but to become people-centred in a way that fosters relationships of trust, leading to improved health outcomes, requires more than simply disseminating skills or best practices (10). First, providers must be persuaded of the benefits of improving their communication skills. This is accomplished by addressing the barriers to constructive provider–patient communication (both real and perceived), and by demonstrating that patient behaviours are largely the outcomes of the provider's communication practices. In short, the same communication principles generally taught to providers on building trust and improving treatment adherence should be used to design a training course to reduce provider resistance and improve skills.

## METHODS AND RESULTS

This case study highlights efforts made in Kazakhstan, with the support of the WHO European Centre for Primary Health Care and the cooperation of the Ministry of Health of Kazakhstan, to design and deliver a tailored communication skills training course for primary health care providers. The aim was to encourage a shift towards people-centredness and effective counselling for health behaviour change. However, to make such training effective, the contextual nature of existing provider–patient relationships and the barriers to increasing trust and collaboration between providers and patients were first examined. The project stages and timeline were as follows:

- Stage 1: assessment of patient needs and satisfaction in pilot provinces (May 2015);
- Stage 2: assessment of provider needs in pilot provinces (December 2015);
- Stage 3: pilot training session for selected providers (March 2016);
- Stage 4: revised training sessions with larger groups of providers in both pilot provinces (June 2016);
- Stage 5: follow-up visits to medical facilities in pilot provinces for observation and supportive supervision (January 2017); and
- Stage 6: training sessions in rural medical facilities to strengthen communication skills and provide new training materials (May 2017).

Each stage of this project informed the next stage, and the case study follows this sequence. Firstly, the process of assessing the needs of both patients and providers is explained. Next, the design and implementation of the training course (including assessing the perspectives and challenges of both parties) and the feedback loops to improve the training materials are explained. Finally, the outcomes of the training sessions are described, along with the lessons learned from these efforts and a general discussion of the role that communication training for providers can continue to have in strengthening primary health care.

### STAGE 1: ASSESSMENT OF PATIENT NEEDS AND SATISFACTION

In collaboration with United Nations agencies and as part of an effort to improve health outcomes, the WHO Regional

Office for Europe conducted a rapid assessment of the health systems in two pilot provinces of Kazakhstan: Mangystau and Kyzylorda. The assessment determined that increasing patient engagement as well as integrating the role of patients into health care policies would strengthen primary health care and lead to improved health outcomes for patients. As a result, WHO proposed an investigation of patient perspectives to develop strategies to improve patient engagement.

A total of 14 focus groups involving patients across the two provinces were conducted in private rooms within the polyclinics (Table 1). To prevent bias or coercion in patient feedback, respectively, participants were recruited from those patients attending the polyclinics on those days and the presence of health care staff was not permitted. Focus group discussions were recorded and transcribed, and the texts were analysed and encoded for themes related to patient perspectives and satisfaction (Table 2).

### RESULTS

Among the patient perspectives of their experiences with the health system was dissatisfaction with provider–patient interactions in primary health care, primarily due to provider behaviours. Although a few institutional factors (such as condition of the facilities or staffing levels) influenced patient satisfaction, it was apparent that a significant improvement could be made by focusing on the communication skills of providers. Dissatisfaction and distrust in patients negatively affect service utilization, information disclosure, treatment adherence and health behaviour change (2, 4). The overwhelming majority of patient complaints registered in Kazakhstan relate to dissatisfaction with how their needs were addressed by medical personnel (11). Such dissatisfaction affects not only patient attitudes towards the health system but also their health outcomes. Good relationships with health care providers are highly important to patients in Kazakhstan (12), but patient expectations and provider behaviour were not conducive to building relationships of trust. Patients tend to perceive their health determinants to relate to uncontrollable factors such as ethnicity (13) or to provider intervention and not to their own health choices and lifestyles (14). To address these misconceptions, communication training for providers was determined to be an effective intervention to not only improve routine provider–patient interactions but also address the other factors identified in the patient survey. Other expected outcomes for patients were increased trust in the health system and a greater understanding that they can improve their health by lifestyle changes.

TABLE 1. DEMOGRAPHIC INFORMATION ON PATIENTS PARTICIPATING IN FOCUS GROUPS

Province	Participants	Sex	Ethnicity	Age (years)	Facilities
Mangystau	9.2 per group (55 in total), six groups	M: 20 (36.4%); F: 35 (63.6%)	Kazakh: 51 (93%); Russian: 4 (7%)	50.1 (19–78)	City Polyclinic No. 2, Aktau city Rural General Practitioner Center, Akshukur village Rayon Polyclinic, Fort Shevchenko Rayon Hospital, Fort Shevchenko Oblast Hospital, Aktau city City Polyclinic No. 1, Aktau city
Kyzylorda	8.4 per group (67 in total), eight groups	M: 26 (39%); F: 41 (61%)	Kazakh: 62 (92%); Russian: 5 (8%)	56.7 (35–79)	Polyclinic No. 1, Kyzylorda Polyclinic No. 2, Kyzylorda Polyclinic No. 3, Kyzylorda Polyclinic No. 6, Kyzylorda Hospital, Kyzylorda Hospital, Shagansk Polyclinic/outpatient clinic, Terenozek Polyclinic, Shagansk

F: female; M: male.

TABLE 2. SUMMARY OF PATIENT PERSPECTIVES GIVEN IN FOCUS GROUPS

Discussion topic	Category	Codes
Navigating the health care system	Access (quality)	Corruption Price Private
	Access (timely)	Facilities (distance) Queues Staffing Severity of health condition
Health care provider interactions	Attitude of provider	Explains everything Gives personal attention Listens carefully Respectful Supportive (kind)
	Attributes of provider	Able to cure Continued learning Familiarity Formal education
Treatment adherence	External factors	Dependence Environment Faith Powerlessness
	Internal factors	Cultural identity Lifestyle (diet & physical activity) Self-efficacy

## STAGE 2: ASSESSMENT OF PROVIDER NEEDS

In this stage, a total of 10 focus groups were held with general practitioners or nurses (Table 3). To eliminate the potential for coercion, managers and administration was not permitted to attend. As in Stage 1, focus group discussions were recorded and

transcribed for analysis. This assessment provided information on the perspectives of primary health care providers towards patient communication and systemic challenges (Table 4), as well as demonstrating to providers that their perspectives and challenges were not being ignored.

**TABLE 3. DEMOGRAPHIC INFORMATION ON PROVIDERS PARTICIPATING IN FOCUS GROUPS**

Province	Participants	Sex	Profession	Age (years)	Facilities
Mangystau	7 per group (28 total), four groups	M: 0 (0%); F: 28 (100%)	Doctors: 12 (two focus groups); Nurses: 16 (two focus groups)	Doctors: 40.6 (26–54); Nurses: 44.8 (24–55)	City Polyclinic No. 2, Aktau city
					Rayon Polyclinic, Fort Shevchenko
Kyzylorda	13.7 per group (82 total), six groups	M: 6 (7.3%); F: 76 (92.7%)	Doctors, 38 (three focus groups); Nurses, 44 (three focus groups)	Doctors: 38.3 (25–66); Nurses: 36.9 (23–55)	Polyclinic No. 1, Kyzylorda
					Polyclinic No. 3, Kyzylorda
					Rayon Polyclinic, Kyzylorda

F: female; M: male.

**TABLE 4. SUMMARY OF PROVIDER PERSPECTIVES GIVEN IN FOCUS GROUPS**

Discussion Topic	Category	Issues
Constraints of the health system	Work conditions	Paid vs free
	Policies	Paperwork Resources Support Workload
Communicating with patients	Provider behaviours	Expertise Positive reinforcement Rapport Trust
	Patient behaviours	Attention-seeking Demanding Disrespect
Treatment adherence	Barriers reported by patients	Kazakh identity Self-efficacy
	Barriers reported by providers	Economic status Perceived severity Personal responsibility Preventive mindset

## RESULTS

The perspectives of providers could be categorized into three main areas: (i) the constraints in performing their work caused by the health care system; (ii) how they view communication between themselves and their patients; (iii) and their perspectives and experiences about patient adherence to treatment.

Regarding systemic constraints, the providers said that large amounts of paperwork and limited resources that made it difficult to perform their jobs and that health care policies were negatively affecting patient behaviours. As for communicating with patients, the providers focused on their own communication behaviours, which they believed helped them in dealing with patients, and on patient communication

behaviours, which they thought hindered positive interactions. Lastly, provider reports on patient adherence to treatment could be categorized into two main areas: barriers to treatment adherence as reported by patients to providers; and barriers to treatment adherence as perceived by providers. Providers reported not only what patients had told them but also their own beliefs on the barriers to behavioural change and treatment adherence. This revealed that perceptions of the behaviour and attitudes of providers towards patients was often an area of discrepancy between providers and patients.

The reports of administrative barriers were important because they revealed that providers believed that, in addition to issues with the patients themselves, external factors were influencing patient communication. However, these accounts lacked a sense of self-reflection, which communication training can address. More importantly, the focus on administrative barriers and problem patients revealed a possible resistance to communication training which ignored these external factors and solely focused on changing the behaviour of providers, as if suggesting they were the sole cause of the problems.

### STAGE 3: PILOT TRAINING SESSION FOR SELECTED PROVIDERS

After assessing the perspectives of both patients and primary health care providers, a communication skills training course was designed to improve provider communication through building trust and supporting behaviour change. The training materials used at this early stage were derived from previous research on evidence-based practices in provider–patient communication that had improved people-centredness and encouraged patient participation in decision-making (15). Additionally, strategies for changing communication behaviour (such as motivational interviewing) were included to address the difficulties described by providers of patient non-adherence to treatment and failure to change unhealthy lifestyles (16). Lastly, a session on understanding and avoiding emotional burnout was included in response to the highly emotional content of accounts given by providers. Before delivering the training course to larger numbers of providers in the pilot provinces, training materials were first piloted in a selected group of providers. The goals of the pilot training session were to deliver information and improve skills in identified areas and to obtain feedback from participants on modifications or additions.

### RESULTS

The pilot training session indicated a need for modifications such as adding more practical exercises such as role play, condensing information into manageable amounts, spending

more time on how to respond to aggressive patients, and more practice with patients with different health behaviours in the session on communicating the need for behavioural change. To make the information more easily applicable, sessions were altered to begin with participants demonstrating their existing knowledge and practices, and corrections then offered with trainers modelling more effective communication strategies.

### STAGE 4: REVISED TRAINING SESSIONS WITH LARGER GROUPS OF PROVIDERS

A larger training session was held in each province, with participants chosen by the local department of health. In addition to doctors and nurses, some psychologists and social workers employed at the polyclinics also attended. Approximately six months after this training session, follow-up site visits to clinics were carried out to observe communication between training session participants and their patients. Based on these observations, communication training materials were further tailored to primary health care providers working in rural clinics of the two provinces. In total, approximately 392 providers across the two provinces received training (Fig. 1).

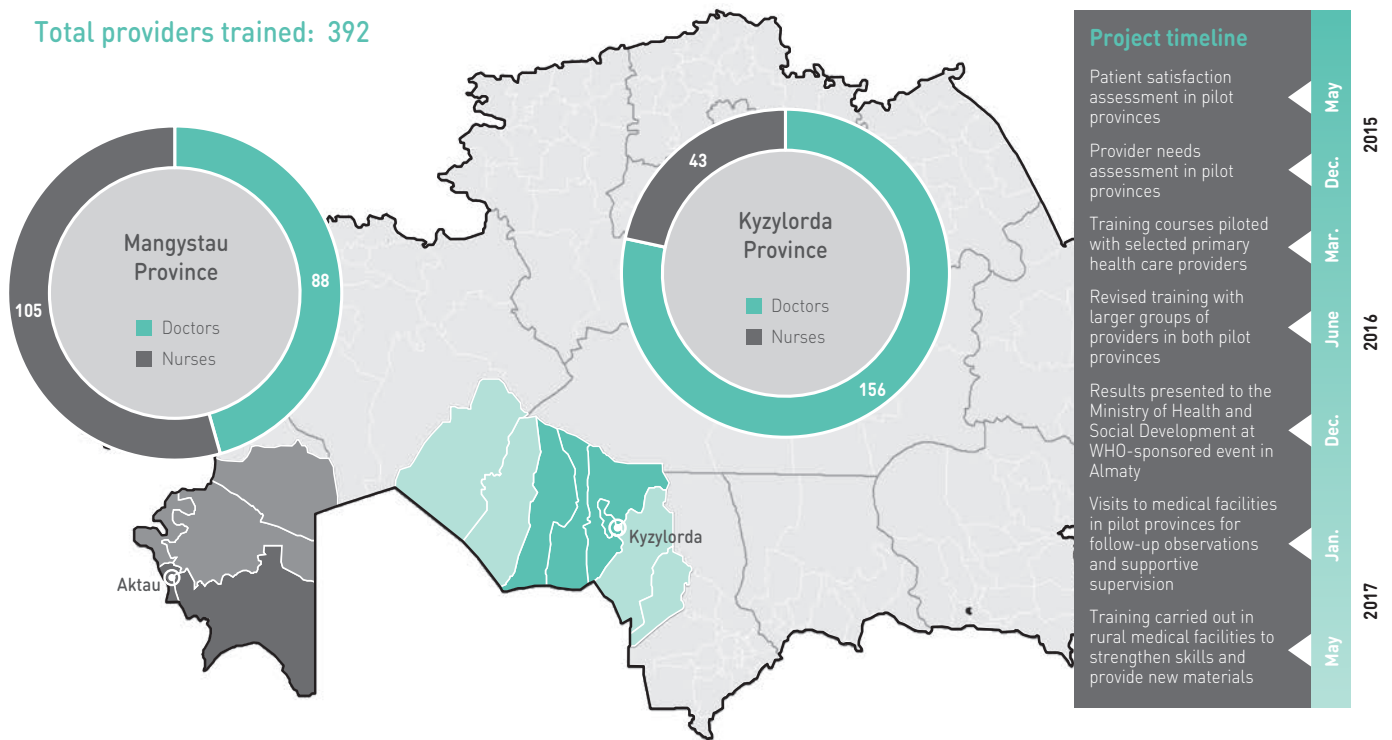
### RESULTS

The effectiveness of the training course and participant feedback were measured to make ongoing adjustments for customizing and improving the training course. The Provider–Patient Orientation Scale (PPOS) (1) was administered to participants before and after the training session to measure any changes to the providers' orientation towards the provider–patient relationship. Mean PPOS scores before and after testing were analysed in a paired samples *t*-test. This analysis consistently revealed an overall shift towards more people-centredness among participants.

In addition to the PPOS, the post-test included a sample dialogue between a provider and a patient as a qualitative component. Participants were asked to respond to and assess the sample dialogue using concepts derived from the training materials. This portion of the post-test was used to determine the concepts that participants had most focused on and learned. Anonymized feedback forms were also distributed at the end of the training session in which participants were asked what aspects of training they had found to be beneficial, whether their perspective of the patient interaction had changed and what components of the training course could be improved.

Overall, the participants felt that communication training was beneficial because it helped them to better understand their patients and that they were now better able to support them. Specifically, participants noted that the areas focusing

FIG. 1. TOTAL NUMBER OF PRIMARY HEALTH CARE PROVIDERS TRAINED AND PROJECT TIMELINE.



"We rarely have been paying attention to our communication at work which is why we have complaints from patients. After the training I now understand most of the problems we have is due to how we communicate with patients and we can solve them by using the skills from the training. We need to start with improving ourselves, even in such basic things as how we greet each other and our patients." (participant)

on active listening, behaviour change communication and managing aggressive patients were most helpful.

### STAGE 5: FOLLOW-UP VISITS TO MEDICAL FACILITIES FOR OBSERVATION AND SUPPORTIVE SUPERVISION

Follow-up visits to some polyclinics at approximately six months after the last training session revealed a continued change in attitude of those primary health care providers who had received training. Some providers who had attended the training course reported on successful changes they had made to their practices and said that their patients were responding positively to these changes.

However, observations also revealed persistent, significant gaps in self-awareness and in communication for building positive relationships of trust with patients. These included:

- not greeting the patient upon entering the general practitioner's office;
- not introducing the doctor (with name or title);
- not using the patient's name;

- making little to no eye contact with patient;
- facial expressions failing to demonstrate attentiveness or caring;
- body language failing to communicate listening or attentiveness;
- not demonstrating active listening and understanding of the patient's needs and concerns; and
- providing limited or no explanations.

To address these issues, the training materials were further modified to include more basic communication techniques (both verbal and nonverbal) to be practiced from the initial contact with a patient. These are needed to help overcome the distrust that so many patients feel towards their health care providers based on their attitude towards the health care system as a whole.

Although efforts had already been made to customize the training materials, the observations revealed an even greater need for changes in impression management (i.e. in greeting



the patient and establishing rapport), self-awareness and the skills to achieve behaviour change.

### STAGE 6: TRAINING SESSIONS IN RURAL MEDICAL FACILITIES TO STRENGTHEN SKILLS AND PROVIDE NEW MATERIALS

Training materials were further modified to strengthen self-reflection and commitment to improving communication among primary health care providers. Rather than presenting communication skills as best practices, problems were first discussed and participants were then invited to demonstrate their typical behaviour and communication style in these situations. This exercise allowed participants to be presented with the possible negative outcomes of these efforts and then learn how to improve them to achieve a more desirable result. This emphasis also stimulated better discussion and more questions about providers' specific experiences and difficulties in rural health care facilities, thus further presenting the training course as a response to the problems as they see them rather than an administrative mandate.

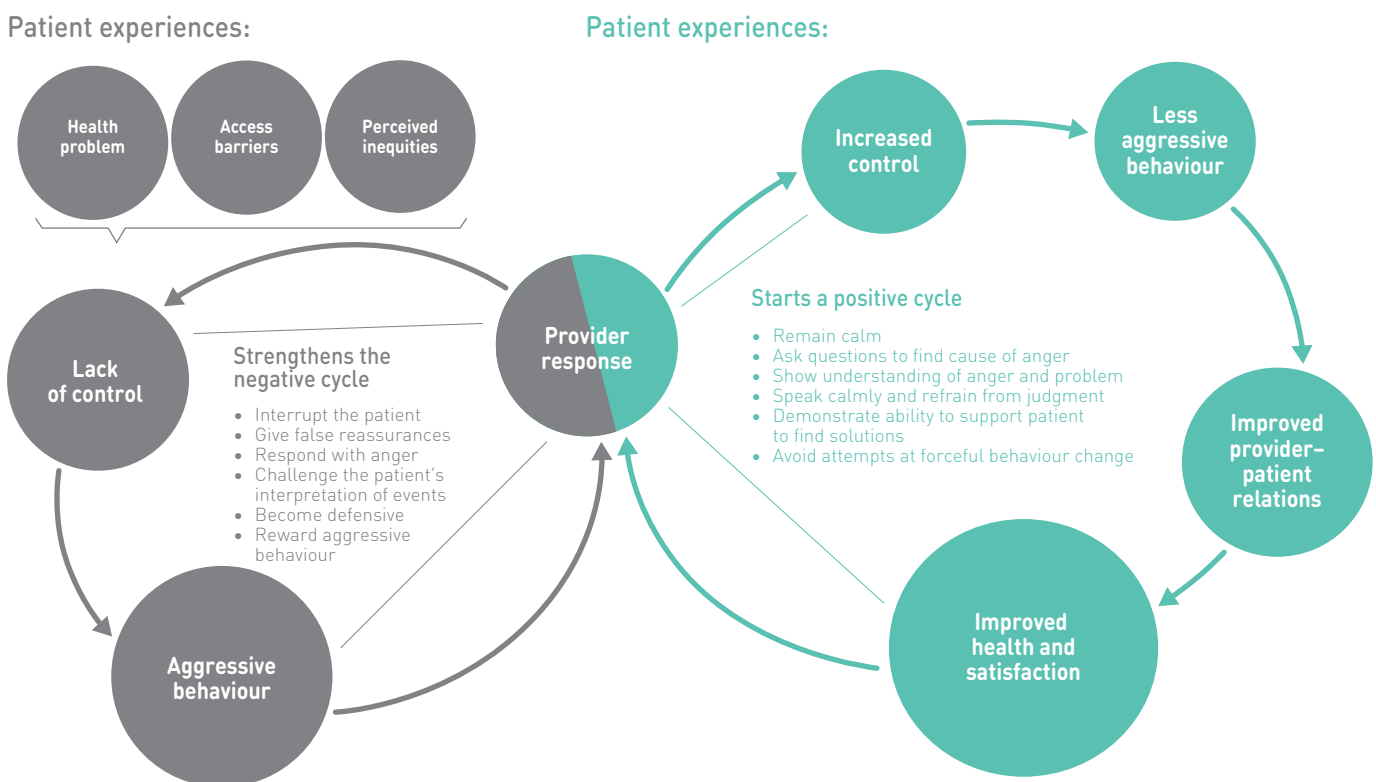
The final training courses delivered in rural polyclinics featured further modifications, including a greater emphasis on the providers introducing themselves and their nonverbal communication with patients, demonstrating listening and understanding through verbal and nonverbal behaviours,

responding to and preventing aggressive behaviour, checking for patient understanding and treatment adherence, and self- and peer-assessments to improve communication practices over time. Some of the topics most requested by providers in rural settings are not commonly included in provider communication training and thus required a greater effort to translate research on the various aspects of health communication into practices that would yield desired outcomes. An example of these translational materials can be found in the training materials on responding to aggressive patient behaviour, a common need among providers in Kazakhstan (Fig. 2).

### LESSONS LEARNED FROM TAILORING A COMMUNICATION TRAINING COURSE

When designed so that it can be tailored to the circumstances and perspectives of primary health care providers working in different health care settings, communication skills training is effective in changing the attitudes of providers towards their patients. This first step in changing attitudes and raising awareness is essential: without it, provider resistance will not be overcome and newly taught skills will not be used with patients. Through a change in their attitudes and awareness in these areas, providers became prepared to and interested in learning skills to improve their communication with patients. The effectiveness of this approach relies on accurately assessing

FIG. 2. RESPONDING TO AGGRESSIVE PATIENT BEHAVIOUR



provider perspectives and current provider practices, which are best observed in clinical settings. The site visits could have benefited the design of this training course even more if they had been carried out at an earlier stage rather than after conducting the large training session.

The importance of tailoring communication training materials to the specific contextual needs of providers can be seen in the way that the session on behaviour change communication was addressed. While based on behaviour change research and using strategies such as motivational interviewing, this portion of the training course also aimed to address local behavioural issues, some of which are not extensively covered in the literature yet are common barriers to provider communicating with patients in Kazakhstan. Examples of these barriers include behaviours attached to ethnic and cultural identities (13), as well as other social factors such as traditional gender roles and domestic responsibilities. By their continuous adaptation throughout the project, the training materials became more effective at meeting the needs of providers and at increasing their commitment to improve communication; however, they also showed that further research is needed on the more contextual factors that affect communication in health care.

Perhaps the most important lesson learned from this process was that, in addition to assessing provider perspectives through focus groups, the training course must be formatted to address the needs of providers and thereby overcome their resistance and increase their commitment to changing their communication behaviour. The focus groups showed that resistance to a people-centred approach, including communication training, can come from the belief of providers that they are powerless against patient complaints, non-adherence to treatment and aggressive behaviour. Therefore, empowering patients through engagement and shared decision-making would be perceived to further decrease their authority and influence over patients. To avoid this problem, the training course had to be framed as providing support for providers rather than correcting their behaviours towards patients.

Each training session began with the participants identifying the challenges and barriers they experience in working with patients in polyclinics. These challenges were then categorized as being either within the power of the providers to change or outside of their realm of influence. By summarizing the challenges to patient communication, trainers could then provide a framework for participants to understand all subsequent training material. This opening exercise enabled the participants to identify their own problems so that trainers

could deliver tailored solutions. Thus, all communication skills subsequently modelled and practiced in the training sessions were readily accepted by the participants.

The challenges identified by participants were acknowledged with empathy and solutions were solicited from the participants themselves. Evidence-based practices were offered as suggestions, as was research into patient perspectives of provider communication. Some challenges identified by participants went beyond the provider-patient interview and included dealing with patients who had waited in queues for long periods and aggressive patients demanding unnecessary or incorrect medications, treatment or hospitalization. Communication skills that related to persuading, rather than informing, appeared to be most relevant for participants. The main topics of the training course were informed by the needs assessments. Although they did not change much from session to session, the approaches to overcoming provider resistance through problem-identifying activities and more role play activities based on local situations improved both reception of the training course and its effectiveness in developing new skills and self-awareness.

### HELPING PROVIDERS TRANSLATE COMMUNICATION PRINCIPLES INTO CLINICAL PRACTICE

Health care providers usually do not see communication as an integral part of their responsibilities and they often resist managerial directives to improve it (18, 19). One reason for resistance is the challenge of transferring the skills learned to clinical practice (20). Standard communication training such as the Health Professionals Core Communication Curriculum (21) covers important people-centred communication skills regarding patient health and care, but providers often perceive this as a burdensome set of prescriptive steps or rules that are only applicable in extreme cases (22). Communication skills are perceived as not necessarily applicable in normal clinical practice, with their use only benefiting the patient's disposition and most providers preferring not to think about these skills.

However, because patient complaints are used to rate medical facilities in Kazakhstan, both administrators and providers have an interest in reducing patient complaints (23). Therefore, communication training for providers can be more effective if it is not limited to disseminating knowledge and skills but is carried out in a persuasive manner that shows, at least partly, that improving communication benefits both the patient and provider and directly affects health outcomes. To achieve this, trainers must model the communication principles they



aim to teach providers. Listening to one's audience in order to adapt the message to their needs and having the ability to demonstrate understanding are the first steps. To overcome provider resistance and improve attitudes towards patients, the needs and perspectives of providers were assessed before designing and delivering the training course. This allowed the trainers to demonstrate an understanding of the constraints faced by providers in treating patients and to consider these constraints when designing effective communication strategies.

## DISCUSSION AND CONCLUSION

This training course has been effective largely because the necessary initial steps of gathering information on the experiences and problems as perceived by first patients and then primary health care providers. These assessments identified the specific circumstances related to delivering and receiving health care in Kazakhstan and provides tailored solutions to local problems in the training course. Additionally, trainers modelled the communication behaviours required by health care providers. Framing the training course in this way is essential to break down resistance and increase the commitment of providers to use their new skills in interactions with patients.

The participants generally struggled to apply the knowledge and skills they had just learned in role-playing exercises. However, they consistently showed in discussions and in post-test qualitative assessments that they had made significant improvements in identifying problematic communication behaviours and their subsequent undesirable outcomes. The identification of problems is an important improvement in the self-examination of communication practices and understanding their possible outcomes. Communication skills can be learned and applied with ongoing practice and experience, but the fact that participants learned to identify problems and undesirable consequences associated with their current practices is a strong foundation on which to improve their skills and practice.

As health care systems work towards a people-centred approach, providers need to be supported in adopting a people-centred approach to care. Communicating with patients in a manner that builds trust and strengthens the provider-patient relationship is an essential aspect of people-centred care, which helps the provider discover the patient's needs and expectations. Communication skills training can and

should be given to providers. However, to change providers' attitude towards patients and encourage their commitment to improving their communication skills, it is necessary to first understand the challenges perceived by providers and then to tailor the training course to provide a series of solutions to those challenges. Similarly, administrators, government officials, experts and trainers need to first listen to providers if they expect providers to then listen to them.

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