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**Lead-*in*-Care: A Qualitative Informed Digital Training Platform Development to
Increase Physicians' Soft Communication Skills After COVID-19**

20 Abstract

21 The post-COVID-19 pandemic era has placed new demands on physicians. One of
22 these demands is the need to use targeted knowledge and soft communication skills, to
23 address the psychosocial problems (e.g., vaccine hesitancy, fears) of individuals with Chronic
24 Physical Illnesses (CPIs). Focusing on training physicians in targeted soft communication
25 skills can address psychosocial-type problems, yet, are rarely implemented, effectively.

26 This study aimed to (a) understand physicians' implementation challenges when using
27 soft communication skills during the COVID-19 pandemic; (b) identify beliefs, barriers, and
28 facilitators that can influence physicians' behaviours to use soft communication skills; and
29 (c) inform the content of the Lead-in-Care; a new digital training platform, designed to
30 improve physicians' soft communication skills by leveraging the TDF Theoretical Domain
31 Framework (TDF).

32 We conducted 14 in-depth semi-structured interviews with Greek physicians, supporting non-
33 COVID-19 cases with CPIs and analyzed their data using inductive and deductive analytic
34 approaches.

35 Physicians highlighted time, inability to see patients in person, absence of space for
36 non-COVID-19 cases, and poor organizational procedures as barriers to using soft
37 communication skills. Five TDF domains were identified as the most salient to inform the
38 platform: practical and well-organized *knowledge; skills* that support patients and their
39 relatives; increase physicians' *beliefs about capabilities* to use the skills; enhance *beliefs*
40 *about consequences* of using the skills (job satisfaction); and develop digital, interactive, and
41 on-demand platforms (*environmental context & resources*). We mapped the beliefs and
42 domains in six narrative-based practices that informed the content of the Lead-in-Care.

43 Physicians need skills that go beyond talking and towards cultivating resilience and
44 flexibility.

45 *Key words: soft communication skills, COVID-19, Theoretical Domain Framework,*

46 *Qualitative study, implementation problem, inductive and deductive analyses*

47

48 **Introduction**

49 During the first and second waves of the COVID-19 pandemic, governments
50 worldwide responded to the increased emergency and intensive care needs by providing
51 hospitals with the necessary funds and equipment to care for critically ill patients (Giang et
52 al., 2020). Yet, additional supplies would not be more helpful now, unless physicians who
53 work in relevant clinical contexts, set a series of practical measures, to address the
54 psychosocial impact of the pandemic. These seem to extend beyond those who suffered and
55 affect different groups of the wider community (Mills et al., 2020; Nicolaou et al., 2021;
56 O'Connor et al., 2021).

57 One group that even during peak COVID-19 periods exhibited a higher prevalence
58 than COVID-19, are patients with Chronic Physical Illnesses (CPIs) (Monaco et al., 2021;
59 Thornton, 2020), particularly the relevant complex cases and those with multi-morbidities
60 (Beard et al., 2016). During the lockdown periods, patients with CPIs experienced a series of
61 psychosocial- type complaints (e.g., unstabilized glycaemic control, non-adherence to
62 medication, excessive fears about COVID-19, etc.) that physicians need now to address, in
63 addition to providing medical care (*The Impact of the COVID-19 Pandemic on*
64 *Noncommunicable Disease Resources and Services: Results of a Rapid Assessment.*, 2020).
65 Previous experiences with epidemics (e.g. Ebola) show that physicians can address the
66 majority of these problems in the first instance and at an outpatient service level, using soft
67 communication skills (Brooks et al., 2020; Finset et al., 2020). Hence, providing first-line
68 physicians with targeted training programs in soft communication skills (Wittenberg et al.,
69 2021) has become a priority for healthcare systems (Appelbom et al., 2021; Dewey et al.,
70 2020).

71 Soft communication skills include a set of modifiable behaviors, including attitudes,
72 ethics, interpersonal abilities, and communication (Joubert et al., 2006). For example,
73 knowing how to announce bad news to patients with compassion and care, or have skills set

74 to promote health behavioral changes, such as medication adherence. Soft communication
75 skills are usually performed in complex settings and influenced by multiple contextual and
76 individual factors (Zulman et al., 2020). Given the significant multilevel influence of soft
77 communication skills, what should precede a training development program, is the
78 identification of what soft communication skills should be emphasized (Cabana et al., 1999),
79 and what barriers and facilitators are likely to support or hinder such a training program.
80 Assessing physicians' needs around these two parameters can provide meaningful
81 information that will prevent the unnecessary delivery of training skills that are not relevant
82 or not needed in the post-pandemic era.

83 In this study, we focused exclusively on first-line physicians, following relevant
84 research that indicated physicians experienced the highest burden among healthcare
85 professionals during the COVID-19 period (Liu et al., 2020; Mheidly et al., 2020). Further, to
86 our knowledge, this is the first study that employs an established implementation framework,
87 named Theoretical Domain Framework (TDF)(Michie, 2005), to identify the factors that can
88 support physicians in routinely using soft communication skills.

89 The TDF was developed to maximize the accessibility of psychological theories of
90 behavioral changes. It is a research method tool that helps implementation scientists identify
91 influences on healthcare professional behaviours (Atkins et al., 2017). This includes the
92 identification of barriers and facilitators, related to applications of evidence-based guidelines
93 (Michie, 2005; Michie & Johnston, 2012). The framework was developed by synthesizing 33
94 behavioral theories, grouped into 14 domains (Cane et al., 2012) that cover several individual
95 and organizational theories (e.g., e.g., “emotions”, social/professional role and identity”). The
96 domains provide a theoretical lens through which one can identify all the cognitive, affective,
97 and environmental influences on behavior. The TDF has been applied in many areas where
98 changing physicians' behaviour is important and to better understand parameters that may

99 facilitate or hinder an intervention's success (Abboud et al., 2022; Connell et al., 2014;
100 Curran et al., 2013; Debono et al., 2017; Gondi et al., 2021; Huyer et al., 2018, 2018;
101 Merianos et al., 2022; the Canada PRIME Plus Team et al., 2012). Despite its popularity,
102 TDF has not yet been applied to understand physicians' challenges in implementing soft
103 communication skills.

104 This study aimed to: (1) understand implementation challenges physicians faced in
105 using soft communication skills during the COVID-19 pandemic; (2) identify and select
106 prominent TDF domains and beliefs that are likely to influence physicians' behaviours to
107 using soft communication skills; and (3) develop narrative practices to inform the content of
108 a digital training platform, called Lead-in-Care.

109 **2. Materials and Methods**

110 ***2.1. Methodology***

111 This study used a qualitative semi-structured one-on-one interviews with physicians
112 from Greece that, during COVID-19, supported non-COVID-19 patients with CPIs. We
113 followed the subtle realism (Pope & Mays, 2020) as an epistemological position; recognising
114 that researchers are not entirely independent and value-free from data analyses and
115 interpretation. Additionally, in this study, we used the Framework for participation approach
116 (Wilcox, 1994) to develop the themes for the Lead-in-Care training platform. The study also
117 applied the consolidated criteria for reporting qualitative research (COREQ) (Tong et al.,
118 2007) and the SQUIRE 2.0 publication guidelines (18 items).

119 ***2.2. Recruitment & Participants***

120 The study employed a purposive sampling procedure (Palinkas et al., 2015), followed
121 by a snowball-sampling technique, asking physicians from the purposive sampling pool, to
122 suggest at least one colleague whom they thought differed in their training and practice. We
123 circulated a flyer via digital social groups of physicians to identify the relevant sample. The

124 research assistants recruited physicians which were geographically dispersed, from suburban
125 and semi-rural areas of Greece, representing different clinical specialties (e.g., Pathologists,
126 Cardiologists, Orthopaedics, etc.), regions in which employed, gender, and clinical settings
127 (primary and secondary health care units).

128 Inclusion criteria consisted of physicians with at least two years of specialty
129 experience (certified and specialized physicians) who during the COVID-19 first breakout in
130 Greece (March 2020) provided care to patients with chronic illnesses (e.g., cardiovascular
131 diseases, asthma, diabetes, etc.), yet, did not involve in treating COVID-19 patients. We
132 excluded participants with a specialty in Psychiatry, those with significant proven experience
133 of soft communication skills (e.g., attended a fully certificated program), and those working
134 in laboratory-based specialists (e.g., Microbiologists, etc.). Thirty-two individuals expressed
135 interest. Eight were ineligible, four were not contactable, and two opted not to participate due
136 to competing commitments. Interviews lasted between 28 and 55 minutes and the mean
137 duration was 40.79 minutes ($SD = 7.73$). The saturation on the topic discussed was reached
138 after the first 10 interviews.

139 **2.3. Data collection and Materials**

140 The study followed an interview guide, consisting of two interrelated parts (see
141 Supplementary Material S1), including questions to elicit physicians' perceived challenges
142 encountered during and after the first nationwide lockdown period in Greece (March- June
143 2020), and those capturing the TDF inquiry (Atkins et al., 2017). The topic guide was drafted
144 from an interdisciplinary team, consisting of a male Clinical Psychologist (X; masked for
145 reviewing purposes; MRP), a team of three females Qualitative Researchers with expertise in
146 Counseling Skills (x; MRP), and a male digital health Consultant (x; MRP). The questions
147 were reviewed by a practicing clinician and pilot tested with two participants. The team

148 endorsed the final version of the guide and the accurate representation of the research
149 questions, ensuring that the TDF domains are adequately covered in the interview.

150 **2.4. Procedures**

151 Two research assistants with experience in qualitative research were trained in the
152 TDF framework and conducted the interviews. The research assistants sent a link to potential
153 participants, explaining the purpose of the study, and asked them to read the information
154 sheet before signing the consent form. Then, the participant was invited to an online
155 interview via the Zoom platform. All the interviews were digitally recorded as word files,
156 transcribed verbatim in Greek, examined against the recordings to ensure correctness, and
157 anonymized. They are then stored in an encrypted data repository in X (MBR). The study
158 was approved by X ethics committee (x; MRP). The research assistants completed all the
159 interviews without the presence of a third person in July- September 2020. Physicians
160 received a 100€ honorarium coupon for their participation.

161 **2.5. Analyses**

162 We employed a two-stage analysis, adopting abductive logic (Pope & Mays, 2020)
163 through inductive and deductive reasoning. In the first stage, the research team analysed the
164 data with primary inductive coding (Isari & Purkos, 2015), tapping on the first aim. For this
165 analysis, two coders, independently, read and reread, all the transcribed interviews- and their
166 reflective notes- and highlighted passages, making notes about patterns and ideas. Next, they
167 interrogated systematically the data, related to the first two interview transcripts, combining
168 codes into patterns and provisional subthemes until candidate themes were generated. They
169 then grouped the threads with similar meanings or those which overlapped, into the same
170 provisional themes, and then named them. After assigning codes to the first two interview
171 transcripts, the coders met to compare their coding, and resolved any differences in the

172 coding with the presence of a mediator. The coders completed the analysis of the remaining
173 twelve interviews using the agreed coding and theme premises.

174 In stage two, the research team first employed Steps 1 and 2 of the Action, Actor,
175 Context, Target, Time (AACTT) Framework (Presseau et al., 2019) to clarify “who” needs to
176 do, “what” differently, “when” (time), and “where” (context), After this, a deductive
177 approach using the TDF constructs’ definitions generated the framework for thematic
178 analysis and examined barriers and enablers that need to be addressed through determinants
179 (grouping factors) that elicit first-line physicians to increase the use of soft communication
180 skills (targeted behaviour).

181 For this analysis, firstly, the two coders interrogated the interviews’ transcripts
182 independently, assigning codes to direct quotes of participants by attributing these to one of
183 the 14 domains/themes of the TDF. Next, one coder (X; MRP) generated a list of beliefs per
184 TDF domain by grouping participants’ responses into similar underlying meanings while the
185 other coder reviewed the generated lists of beliefs (X; MRP). The generated beliefs per TDF
186 domain provided details about how each identified domain (e.g., environmental context and
187 resources) could support the targeted behavior (i.e., influence physicians to routinely use soft
188 communication skills). A domain was rated “important” by the two coders and mediator if
189 beliefs were frequently indicated that it might influence physicians' behaviors (i.e., to use soft
190 communication skills). The research team held 3 half-day workshops over 3-months, to
191 consensually agree on the final selection of the TDF domains (see Supplementary Table S2
192 which tabulates the process of the final selection of TDF and beliefs).

193 Following the completion of data analyses, the research team participated in two
194 online open grouping co-ideation exercises. These meetings aimed to map the identified
195 themes in the Lead-in-Care training platform. First, the researchers who analyzed the data,
196 presented the key findings to the team, using Miro’s infinite whiteboard canvas; an embedded

197 Microsoft Teams application for ideation and planning work. Secondly, the research team
198 conducted a real-time ideation exercise where they discussed the findings, by brainstorming
199 with the assistance of Miro's facilitation tools, such as sticky notes, arrows, voting, timers,
200 etc. One of the main researchers involved in the analyses, shared-to-stage the Miro
201 whiteboard and created real-time different graphs, boxes, etc., so that all involved,
202 collaborate live, and agree, consensually, on the resulting themes. The outcome of this
203 ideation exercise informed the training platform that is illustrated in figure 1.

204 **3. Results**

205 Table 1 presents the demographics and other related information of our sample. The
206 study sample included more females (64%), with a mean age of 44 years old. More than half
207 of the sample had a specialty in internal medicine (57%). There was an equal distribution of
208 physicians working in public and private hospitals (43% each) with 14% working in primary
209 care centres. Half of the participants had acquired a graduate degree. Physicians reported that
210 67% of their daily clinical work time involves care provision to chronic illness patients. More
211 than half (64%) of the sample reported some previous knowledge of soft communication
212 skills (nature of the behavior).

213 *[Table 1 about here]*

214 Illustrative quotes are provided to allow others to judge whether the interpretation we
215 provide to support the study findings is adequately grounded by the data. Each utterance is
216 identified with a unique recognised interview code and numerically, to represent a specific
217 extract from each of the coding interviews (e.g., W20_PT_30).

218 ***3.1. COVID-19 Challenges in Applying Soft communication Skills***

219 As table 2 below shows, all physicians reported their patients' fearful and panicogenic
220 reactions (e.g., *We lost them; all the patients had been terrified and didn't leave their homes;*
221 *W20_AI_73_37, some patients were very panicked; W20_ET_14*), including the need for

222 reassurance to address poor care adherence (e.g., *many times, I had to face patients' denial to*
223 *go to the hospital, I had to refer them, cause they were afraid of COVID-19 infection;*
224 *W20_AD_31*).

225 Physicians described that their patients' reactions, triggered their own stress and
226 insecurity, expressed as concerns about their patients' well-being, including illness
227 complications (e.g., *surgical patients should be always in direct contact with their physicians*
228 *and the units should know any complications, to deal with them at their birth, not to wait*
229 *until the patient dragged into the E.D. So, you can imagine this whole thing generates stress,*
230 *and not only stress, but also insecurity, well, maybe the insecurity generates stress;*
231 *W20_PT_32*).

232 Further, physicians highlighted how contextual parameters lowered their motivation
233 to use soft communication skills, including a lack of resources and staff (e.g., *The core*
234 *challenge was about patients' examination, well, the strict health protocols we had to*
235 *adhere; limiting the appointments in outpatient clinics, limiting the number of nurses who*
236 *serviced the outpatients' units, and the corresponding E.D; W20_PT_26*), their inability to
237 see patients (*it was almost impossible to see a patient; W20_PT_26*), the absence of medical
238 examination rooms for non-COVID-19 cases, and the poor guidance (e.g. what we should do)
239 about non- COVID-19 patients management (e.g., *one thing I faced was doctors' ambiguity,*
240 *there were no guidelines in regional units and primary health centers. We didn't have a*
241 *selection box outside so that we ended up seeing all the patients who had a fever and all the*
242 *emergencies; W20_ET_14*).

243 Notably, physicians managed to quickly overcome communication barriers through
244 frequent use of digital means (e.g., *well, personally, I was able to talk to all of my patients*
245 *with chronic illnesses who had been trapped in rural areas through Skype or Facetime.*
246 *Given the opportunity of the new e-prescribing platform, I was able to send them the*

247 *referrals and the subscriptions, digitally; W20_PA_95_14*). Although they would prefer an
248 in-person communication, their motivation to maintain communication with their patients and
249 provide reassurance, particularly for the elderly and those in rehabilitation or with complex
250 needs, resulted in an increased of empathetic responses to patients' needs, something that was
251 positively perceived by most of them (e.g., *we were trying to reassure them and especially*
252 *those who had a sort of a stable non-other diagnosed condition, who were in remission...so*
253 *that they were not affected by this delay of our appointments. Well, as much as we would be*
254 *able to do this over phones and while not having an in-person contact; W20_DM_04_30*).

255 *[Table 2 about here]*

256 **3.2. Domains and Beliefs likely to influence Physicians Use of Soft communication**

257 **Skills**

258 In total 517 utterances were selected from 14 interviews and coded into the 14 TDF
259 domains. The interrater reliability was acceptable ($k = .62\%$, CI .24 to .81, $p < .01$). In sum, all
260 the theoretical domains were found to play a role in supporting the targeted behaviour (i.e.,
261 increasing the routinely use of soft communication skills in patients with CPIs in the
262 aftermath of the COVID-19 pandemic), yet, one domain (optimism) and six beliefs, mapped
263 on skills, optimism, reinforcement, memory, attention & decision processes, and social
264 influences, respectively, were least frequently raised. After using the three criteria set for
265 selecting specific domains and beliefs, these domains and beliefs were judged inappropriate
266 and excluded (See Supplementary Material S2). The supplementary Material S3 outlines the
267 33 generated beliefs, mapped on the 13 selected domains along with illustrative quotes and
268 the frequency of the belief mentioned by the physicians. Notably, the coded data in the first
269 aim was also deliberately coded in the last two aims, underlying the trustworthiness and
270 credibility of our data analysis and interpretation. For a comprehensive analysis and
271 interpretation per TDF domain, see the Supplementary Material S4.

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[Table 3 about here]

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Among the 13 domains, five were found to be the strongest, including Knowledge, Skills, Beliefs about capabilities, Beliefs about consequences, and Environmental context/resources. Physicians inferred an influence of how specific knowledge (practical, focused, and well-organized information about soft communication skills) can help them develop soft communication skills that guide and support patients and their relatives to cope with the illness. Accordingly, physicians highlighted how their lack of self-confidence in using soft communication skills (beliefs about capabilities) may affect the quality of care provision. Data showed that boosting physicians with appropriate knowledge about soft communication skills (both the core and more advanced skills) and via appropriate means (e.g., examples, experiential self-reflective exercises, etc.), developed through collaborations among various Mental health professionals, associations, and higher educational institutions, and delivered digitally via an on-demand (log-in) platform (*environmental context and resources*); would increase their beliefs about capabilities, hence, increase their willingness to provide empathy that “*goes beyond communication and into patients’ life with sincere interest*”. Notably, increasing physicians’ confidence in the use of soft communication skills would increase physicians’ job satisfaction and patients’ self-management skills (beliefs about consequences).

Capitalizing on the TDF framework, a critical reflection of the beliefs, mapped on the TDF domains, generated specific barriers and facilitators that when applied, can further support the target behavior and even enhance the successful implementation of the Lead-in-Care in clinical settings. The Supplementary Material S3 presents the 19 barriers and 33 facilitators identified from physicians’ interviews.

Some barriers and facilitators mapped cleanly onto specific TDFs, while others purport reciprocal relationships between domains, meaning that they co-occur with other

297 domains, to support the targeted behavior. For example, knowledge and skills share a similar
298 implementation barrier that represents an overall lack of foundation knowledge and skills of
299 soft communication skills. Figure 1 illustrates the synthesis analyses of the TDF, including
300 the mapping process of TDF-related beliefs into six narrative data-informed practices that
301 guided the development of the Lead-in-Care platform’s content.

302 *[Figure 1 about here]*

303 **4. Discussion**

304 This study implemented the TDF in a complex qualitative and participatory design
305 analysis, to inform the development of the Lead-in-Care: a research/enterprise training
306 platform. An interdisciplinary team of behavioral and implementation scientists leveraged
307 modern participatory design processes and psychological and behaviour change technologies
308 (Bavel et al., 2020; Karekla et al., 2021), as per the Medical Research Council (MRC)
309 Framework (Craig et al., 2008), to map the data onto a guiding graph that generated key
310 themes to inform the new platform (see figure 1). The findings showed that time availability
311 and presence have been traditionally reported in the relevant literature as important skills for
312 physicians, working in busy clinical settings (Zulman et al., 2020). Yet, now in the COVID-
313 19 relevant literature, these parameters are also seen as necessary that can increase a sense of
314 safety for patients, particularly during conditions that require physical distance (Maunder et
315 al., 2003; Schlögl & A. Jones, 2020). The study provides data-driven practical,
316 organizational, and policy-based themes. The themes can be used by researchers and
317 implementation sciences as “foci” interventions component that can enhance more patient-
318 centred care.

319 The TDF framework analysis indicated thirteen domains as potentially useful targets.
320 Of those, five seem to be the most influential, including Knowledge (practical, procedural,
321 detailed, and when urgently needed), Skills (learned via practical examples, to guide, support,
322 and provide emotional relief), Beliefs about capabilities (particularly to enhance physicians

323 sense of using soft skill to show empathy, sincere interest, and understanding), Beliefs about
324 consequences (to increase physicians' job satisfaction and patients' self-management skills),
325 and Environmental context/resources (to develop a digital platform via an interdisciplinary
326 team of experts, and then promote the platform via medical directives, associations, and
327 public universities).

328 The findings provide a roadmap towards the development of a training platform that
329 is meant to be physicians' not researchers-led, consistent with premises from participatory-
330 based research (Wright et al., 2018). Data-driven recommendations indicate that the Lead-in-
331 care platform should attempt to manage patients' and physicians' concerns and reactions to
332 mitigate COVID-19 barriers in implementing soft communication skills. This can occur by
333 promoting structural organizational changes (e.g., designated rooms for non-COVID-19
334 cases, clear protocol procedures for non-COVID-19 cases, etc.) and proactive communication
335 skills that will ensure physicians have all the necessary tools to communicate with their
336 patients (e.g., providing access to multiple and different secured platforms for physicians, e.g.
337 via phone web-app based devices). Findings indicate that the platform should include
338 targeted skills that can help physicians address patients' fears, and also help them to promote
339 real expectations about disease management. These should be considered under the rhythm of
340 ongoing changes in relation to COVID-19 mutations, setting premises for an ongoing post-
341 COVID-19 healthcare provision, too.

342 The study findings are in line with recent similar research indicating the barriers and
343 enables in maintaining good health care professionals and patients relationships (McDonnell
344 et al., 2022; Vogt et al., 2023). Some contextual and environmental issues, such as staffing
345 pressures and ongoing workload existed to a large degree before the pandemic but
346 deteriorated by it. Contrary to others' findings, indicating that healthcare after the pandemic
347 became less holistic and patient centred (Curnow et al., 2021), our study findings showed an

348 increased physicians' attention to patients' needs, and physicians' commitment to
349 maintaining good healthcare service, even, remotely. A possible explanation may be
350 attributed to the lockdown measures which lowered the frequency of in-person medical
351 appointments, consequently increasing the time physicians could spend with the remaining
352 patients. For example, physicians used innovative ways to provide care to their patients,
353 leveraging technology (e.g., facetime) even when they reported limited knowledge of its use.
354 Further, physicians reported a lack of training and confidence in delivering soft-
355 communication skills; a finding that is consistent with previous studies (Keyworth et al.,
356 2018), indicating the need for ongoing training provision in soft communication skills.

357 Despite the trustworthiness of the data, we identified several study limitations. Firstly,
358 saturation may have been reached prematurely, given the pressure of time to rapidly identify
359 the training content and develop the Lead-in-Care training platform. Secondly, the sample
360 was relatively small with half of the physicians, consisting of specialists in Internal Medicine.
361 Although the sample size and characteristics were representative of national averages in
362 Greece (Pappas, 2015), including participants from more than a homogenous group of
363 specialists (e.g., Cardiologists), still other groups might have elicited different views against
364 or in favor of the targeted behavior to change. Thirdly, the TDF reflects a group of
365 physicians' views that do not define exclusive influences on the behavior of interest
366 (Arvanitis et al., 2022; Francis et al., 2009; Sissons et al., 2020). There may be other
367 influences that this study has not identified. Step wedge designs are now needed (e.g.,
368 qualitative realist evaluations, pragmatic micro-RCTs, and N-of-1 studies) to assess which of
369 TDF drives behavioral changes. It is possible that if we had triangulated our findings with
370 those coming from CPIs or stakeholders (e.g., clinics' directors), we might have highlighted
371 other parameters to guide the platform's content.

372 In conclusion, this study identified for the first time parameters that would prompt
373 physicians to start using soft communication skills more frequently. It indicated how soft
374 communication skills can be employed to mitigate the psychosocial impacts of the COVID-
375 19 pandemic in patients with CPIs. The findings showed that it is likely to provide brief,
376 focused, and effective soft communication skills to physicians. This can be achieved by
377 developing a digital training platform that should target increasing knowledge and skill and
378 competencies that can enhance physicians' capacity to manage patients' fears relevant to
379 COVID-19. It should also focus on promoting compassionate-based care that goes beyond
380 talking, and towards cultivating resilience and flexibility in both to physicians and individuals
381 with CPIs.

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