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Communication Skills: A Call for Teaching to the Test

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Educational authorities have been calling for improved physician-patient communication for decades, yet students and residents seem to feel less prepared than ever for difficult situations with patients, and patients are becoming less satisfied with physician communication skills.^{1,2} The Association of American Medical Colleges (AAMC) made communication central to its Medical Schools Outcomes Project,³ requiring medical students to pass a clinical skills examination as part of the United States Medical Licensing Examination (USMLE) Step 2. The clinical skills examination includes components of communication,⁴ but there is a paucity of data on the best methods to teach such skills.^{5,6} A recent large and costly intervention using a general communication skills curriculum resulted in only a 5% improvement in student scores.⁷ Most of the published approaches to the teaching of communication suffer from being vague, teacher-dependent, and non-reproducible. For instance, the Kalamazoo Consensus Statement on the essential elements of medical communication in medical encounters delineates 7 tasks, including “build the doctor-patient relationship” and “understand the patient’s perspective.”⁸ More recently, the Accreditation Council for Graduate Medical Education (ACGME) expanded its recommendations for communication competencies to include language such as “Be ‘present,’ paying attention to the patient” and

“Demonstrate effective listening by hearing and understanding in a way that the patient feels heard and understood.”⁹ While these goals are admirable, they are not particularly useful when a student interacts with a patient. What students typically ask when given such vague guidelines is, “But what should I *say*?”

Effective physician-patient communication is central to patient care, and should therefore be a major emphasis of medical education. Yet teaching communication skills has historically been relegated to a sub-component of other curricula or limited to the basics of medical interviewing.^{10,11} The result is that most US medical graduates report little training (and less comfort) in end-of-life communication skills; most residents lack competence in delivering bad news and are unskilled in the use of interpreters; and physician-in-training scores of physician-patient communication in the primary care setting declined from 1996 to 1999.^{1,2,12,13} Not only is patient satisfaction affected by poor communication skills, but there is a significant correlation between effective physician-patient communication and improved health outcomes as well as reductions in malpractice claims.^{14,15}

Educators have shied away from the idea of “teaching to the test” when it comes to communication skills, yet this reluctance leaves physicians-in-training ill-equipped when they are, in fact, tested.^{7,16} This is especially true for “higher order” communication skills; educators tend to approach emotionally charged discussions as very different from “routine” medical interviewing. For example, multiple sources give remarkably similar lists of specific questions to ask patients

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about chest pain (location, duration, timing, exacerbating and alleviating factors, quality, specific associated symptoms, etc), but very little advice is available on how to tell patients the diagnosis. When physicians-in-training enter into difficult discussions, they are forced to do so unrehearsed, which is a disservice to both the physician-in-training and the patient (and imparts the false message that “routine” interviewing is not emotionally difficult for physicians or patients).

Physician-in-training confidence in their general social communication skills might actually hamper performance in clinical interactions,¹⁷ which should not be surprising, as a person who is good at small talk in social settings may believe that connecting with patients is no different.

Yet if physicians-in-training never practice saying “I’m afraid I have some bad news,” they are likely to find themselves at a loss when the time comes to relay bad news to a patient. Some small studies have shown that practicing communication skills tailored to specific situations can improve performance,^{13,18-20} and a randomized controlled trial in which residents were given step-by-step instruction and practice in interviewing for specific situations demonstrated improvement in residents’ abilities to conduct the medical interview.²¹ The General Internal Medicine Generalist Educational Leadership (GIMGEL) Group has published practical recommendations on clinical teaching of psychosocial aspects of patient care, which includes some specific questions addressing topics such as health literacy (“A lot of people have trouble reading things they get from the doctor because of all the medical words. Is it hard for you to read the things you get here?”).²² Specific statements made by clinicians enhance the satisfaction of critically ill patients’ families (eg, assurances that the patient will be comfortable and will not suffer).²³ The next step is the development of a comprehensive curriculum based on clear statements such as these. Students need concrete, situation-specific tasks from which they can build communication skills.

The topic of physician-patient communication is broad, but it can be broken down into specific teachable components. For example, breaking bad news and conducting end-of-life discussions are important situations in which young physicians typically feel the most ill-prepared.^{12,24} Communicating with patients who have limited English proficiency is a rapidly growing problem. Discussing risks and benefits of procedures and obtaining informed consent has been emphasized by the US Agency on Healthcare Research and Quality as vital to patient autonomy and safety.²⁵ These topics, while beyond the basics of the initial medical interview, still

lend themselves to relatively simple scripts. The tasks should be specific and concrete, such as in the suggested sample scripts provided in the Table.^{26,27} Although exact statements made in each particular scenario will differ—obtaining informed consent for an HIV test is different

than obtaining it for a high-risk surgical procedure—the specific tasks themselves (eg, explaining the diagnosis or the problem and explaining the proposed procedure) are fairly uniform. Educators will disagree about the most important scenarios to teach or the appropriateness of individual tasks, and the suggested scripts in the Table are intended to provoke discussion and new suggestions.

Nevertheless, the underlying hypothesis—that communication skills should be taught by giving physicians-in-training explicit step-by-step skills rather than attempting to impart abstract concepts or attitudes—is not dependent on which particular tasks or situations are addressed. Some critics may argue that this approach risks creating automatons that mouth rigid scripts and ignore all the subtleties present in a patient interaction. On the contrary, giving students tools for and practice in making the kinds of statements that are known to be effective in specific situations will help students unlock the mysteries of difficult patient interactions and go on to build unique physician-patient relationships.

If communication tasks were taught in the same way as other skills in medicine, using concrete algorithms that students can adapt and build on as they mature in their clinical abilities, it could markedly change current educational practice. For instance, master clinicians would have a formal structure in which to teach interpersonal skills. Such experts have developed communication skills through experience and mentoring; they all have “scripts” to use in certain situations and it is likely that their scripts share many common elements.^{28,29} Several of the articles in the *Annals of Internal Medicine* series, “Words that Make a Difference,” include brief scripts,^{27,30-33} such as, “I am hoping for the best. I think that, at the same time, we need to prepare for the worst.”³⁰ If more of these scripts could be compiled, they would be a tremendous resource for physicians-in-training. These scripts need not be only written—video scenarios of clinicians in action could help bring the scripts to life.

The current state of knowledge in medical communication education lags far behind that of other educational interventions. There is a notable lack of scholarly assessment of medical communication instruction. Medical educators insist on evidence-based patient

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- Effective physician-patient communication is central to patient care.
- Communication skills should be a major emphasis of medical education.
- Communication “scripts” are a useful tool in medical education curricula.

Table Sample Scripts for Specific Patient Encounters^{26,27}**Giving bad news:**

- Sit down facing the patient, if possible; do not stand over patient or sit on bed.
- Mention the purpose of the meeting: "I'm going to go over the test results with you now."
- Set the stage: "I'm afraid I have some bad news."
- Give the news unequivocally: "The test showed that you do have _____."
- Stay silent while the patient absorbs the news.
- Touch the patient (on the hand, arm, or shoulder only) if it seems appropriate.
- Find out what the patient knows: "Tell me what you know about this illness."
- Show empathy: "I wish I had better news."
- Make a plan for the next step: "Here's what's going to happen next."

Informed consent:

- Explain the diagnosis or the problem: "You've been having chest pain, and we don't know if this pain is coming from your heart."
- Explain the proposed procedure: "We'd like to do something called a heart catheterization . . ."
- Explain the risks of the procedure: "We do everything as carefully as possible, but even when we do everything right, things can go wrong . . ."
- Explain the benefits of the procedure: "The reason I'm recommending that you have this done is because it will tell us if your heart is okay, or if you have a blockage somewhere that needs surgery or another procedure."
- Make sure the patient understands that it is up to him or her to decide: "I'm recommending this, but you are in charge, and you don't have to do this if you don't want to. There are other things we can do if you don't want this."
- Ensure understanding: "Can you tell me in your own words what I've just explained about this procedure?"

Working with an interpreter:

- Determine whether an interpreter is needed: "How is your English?"
- Do not use a family member unless the patient insists and clearly understands that another interpreter can be obtained.
- Do not use a minor child.
- Speak in the first person to the patient: "Tell me what brings you here."
- Look at the patient, not the interpreter or the phone.
- Speak in short phrases.
- Redirect the interpreter if necessary: "Please translate everything the patient is saying."

care, but they also should insist on evidence-based education. A great deal of curriculum development is occurring in the country, but it is rarely subjected to controlled evaluation, meaning that there is almost no evidence upon which to select elements of a curriculum. Adding elements to a curriculum comes at an expense in terms of both time and money,³⁴ so educators need to know what works and what does not. However, for rigorous evaluation of communication teaching methods to be possible, a generally agreed-upon set of critical elements of communication in different settings needs to exist.

Once a communications curriculum is constructed, methods are already in place for teaching and evaluating it. Role-playing is an effective technique for teaching communication skills to medical students³⁵⁻³⁸ as are standardized patient workshops.³⁹ Watching clinicians at work is an invaluable learning experience and while it is unfortunately not feasible for every physician-in-training to be apprenticed to an expert communicator, the use of digital teaching formats shows promise.⁴⁰ Objective structured clinical examinations (OSCEs) are a widely accepted examination technique for clinical competence, including competence in communication.⁴¹⁻⁴³ Moreover, OSCEs are similar in format to the clinical skills examination portion of USMLE Step 2.⁴

New guidelines are mandating that medical education incorporate ideals of patient-centered care, ethics, professionalism, and humanism, and communication skills are central to all of these ideas. To date, no method for achieving these goals has been described. Although it is admittedly hard to teach appropriate behavior and harder still to measure it,⁴⁴ reaching a consensus on the framework of appropriate communication would provide medical educators with a common starting point and provide students with the skills to hit the right notes with patients.

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