ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Report III

Contemporary Issues in Medicine: Communication in Medicine

Medical School Objectives Project

October 1999

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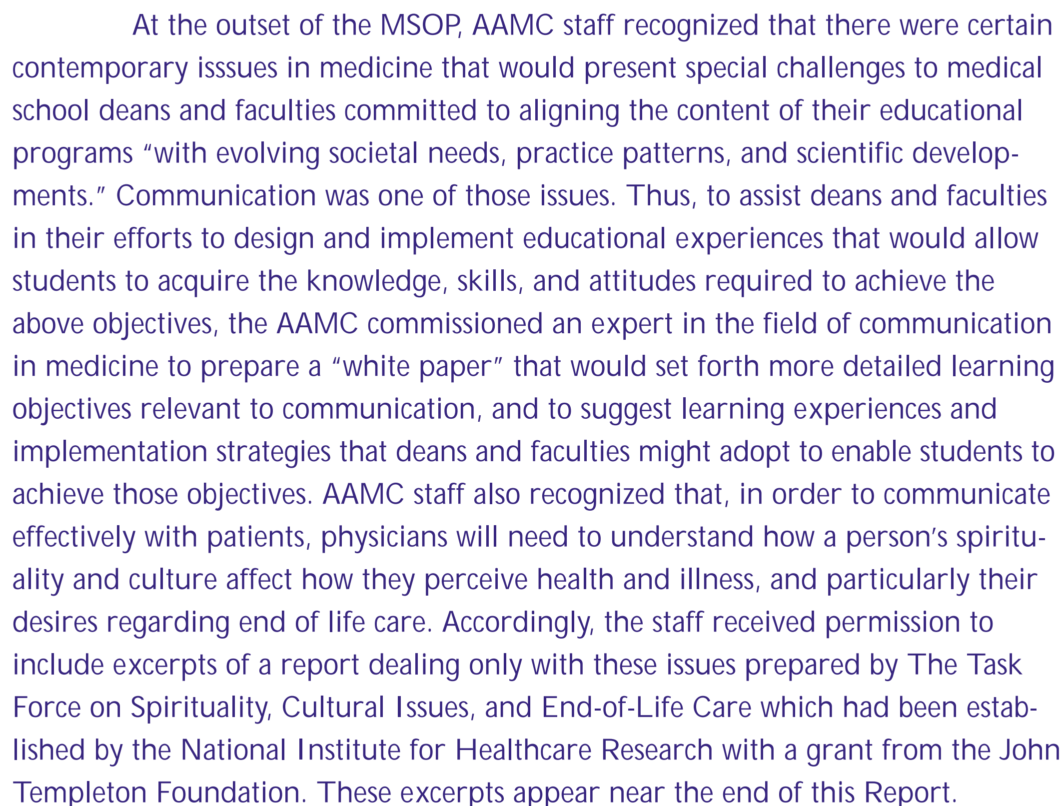
In January 1998, the Association of American Medical Colleges (AAMC) issued Report I of the Medical School Objectives Project (MSOP). The purposes of the MSOP were to set forth program level learning objectives that medical school deans and faculties could use as a guide in reviewing their medical student education programs (initial phase), and to suggest strategies that they might employ in implementing agreed upon changes in those programs (implementation phase). MSOP Report I concluded the initial phase of the project. That report set forth 30 program level learning objectives that represented a consensus within the medical education community on the knowledge, skills, and attitudes that students should possess prior to graduation from medical school.

Report I set forth a number of learning objectives that reflected a growing awareness that, in the future, physicians will be expected to be more effective than now appears to be the case in communicating with patients and their families, and with other members of the health care team. These objectives are restated below:

For its part, the medical school must ensure that, before graduation, a student will have demonstrated, to the satisfaction of the faculty:

- The ability to obtain an accurate medical history that covers all essential aspects of the history, including issues related to age, gender, and socio-economic status
- The ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities
- Knowledge about relieving pain and ameliorating the suffering of patients
- Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies
- Compassionate treatment of patients, and respect for their privacy and dignity



At the outset of the MSOP, AAMC staff recognized that there were certain contemporary isssues in medicine that would present special challenges to medical school deans and faculties committed to aligning the content of their educational programs "with evolving societal needs, practice patterns, and scientific developments." Communication was one of those issues. Thus, to assist deans and faculties in their efforts to design and implement educational experiences that would allow students to acquire the knowledge, skills, and attitudes required to achieve the above objectives, the AAMC commissioned an expert in the field of communication in medicine to prepare a "white paper" that would set forth more detailed learning objectives relevant to communication, and to suggest learning experiences and implementation strategies that deans and faculties might adopt to enable students to achieve those objectives. AAMC staff also recognized that, in order to communicate effectively with patients, physicians will need to understand how a person's spirituality and culture affect how they perceive health and illness, and particularly their desires regarding end of life care. Accordingly, the staff received permission to include excerpts of a report dealing only with these issues prepared by The Task Force on Spirituality, Cultural Issues, and End-of-Life Care which had been established by the National Institute for Healthcare Research with a grant from the John Templeton Foundation. These excerpts appear near the end of this Report.

This report - MSOP III - includes the white paper prepared by Gregory Makoul, Ph.D., Director, Communication in Medicine Program, Northwestern University School of Medicine, and the report prepared by the Task Force on Spirituality, Cultural Issues, and End-of-Life Care. In addition to setting forth detailed learning objectives and suggested learning strategies, the paper prepared by Dr. Makoul provides insight into the current approaches employed for the teaching of communication skills to medical students. This information should be of value to deans and faculties as they evaluate the approaches being used in their schools, and as they consider how to incorporate suggested educational experiences set forth in Dr. Makoul's paper and the report of the Task Force.

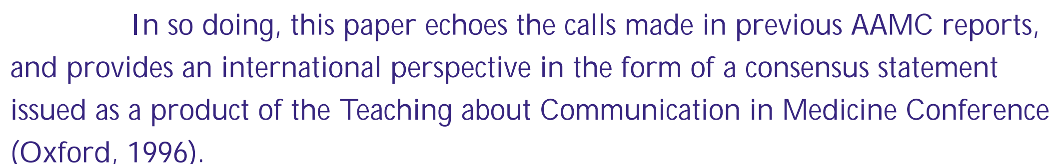
Contemporary Issues in Medicine: Communication in Medicine

While the idea that communication is an essential aspect of medicine is not new,[1,2] it might seem that way, because communication skills teaching and assessment are quickly becoming much more visible in medical education. The activity is not limited to medical schools; residency programs, continuing medical education courses and managed care organizations are also devoting time and resources to communication skills. Two high profile assessment initiatives in the United States parallel this trend: (1) The National Board of Medical Examiners plans to implement a standardized patient test, part of which will focus on communication, as a component of the United States Medical Licensing Examination;[3] (2) The Educational Commission for Foreign Medical Graduates currently administers a clinical skills test, one component of which addresses key dimensions of doctor-patient communication.[4]

The sharpened focus on communication skills is apparent in the literature as well. For instance, in 1996, the *Journal of the American Medical Association* inaugurated a section called The Patient-Physician Relationship. In 1999 the *Journal of Health Communication* unveiled a section on Education and Evaluation. Renewed attention to professionalism in medicine also highlights communication skills.

Taken together, these observations suggest that the apprenticeship model and a conception of communication as "bedside manner" or "history taking" is giving way to more formalized instruction and a reconceptualization of communication as a fundamental clinical skill.[5] This background paper, written for the Association of American Medical Colleges's Medical School Objectives Project (MSOP),[6] is intended to facilitate the process of enhancing communication skills teaching and assessment by:

- Defining the scope of communication and communication skills;
- Discussing the importance of effective communication in medicine;
- Summarizing the current state of communication skills teaching and assessment; and
- Offering an action plan for improving communication skills education.



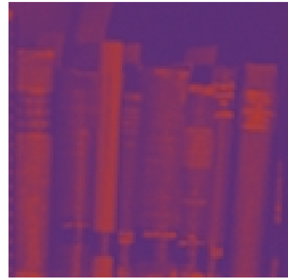
In so doing, this paper echoes the calls made in previous AAMC reports, and provides an international perspective in the form of a consensus statement issued as a product of the Teaching about Communication in Medicine Conference (Oxford, 1996).

The Scope of Communication and Communication Skills

Communication is a complex phenomenon. Definitions vary in their emphasis on the verbal, non-verbal, content, process, informational, relational and cultural aspects of communication. In broad terms, it is perhaps most useful to think about communication as a transactional process in which messages are filtered through the perceptions, emotions and experiences of those involved. Adding to the complexity, communication occurs at several levels, including intrapersonal (e.g., patients' personal constructions of the illness experience), interpersonal, group, organizational, mass, and technological. In addition, communication in medicine can be oral, written, or computer mediated.

While communication at all of these levels and in each of these forms is relevant to medical education, interpersonal communication remains the linchpin of medical practice. At present, interpersonal communication skills instruction tends to focus almost entirely on the physician-patient relationship. Although communication with families may be considered an extension of physician-patient communication, students will need specific instruction and practice in order to work most effectively with family members who accompany patients to physician visits, those who serve as caregivers, and those involved in more difficult situations (e.g., delivering bad news). Communication with physicians and other members of the health-care team also requires curricular attention, given the movement toward better integrated care.

Even the evolution of medical education reinforces the importance of viewing communication in medicine as more than history taking. For instance, as medical schools continue to incorporate small-group learning formats into their curricula, communication skills that facilitate medical practice (e.g., conflict management, team building, public speaking) are quickly becoming necessary tools for effective learning. In addition, new communication technologies (e.g., computer-



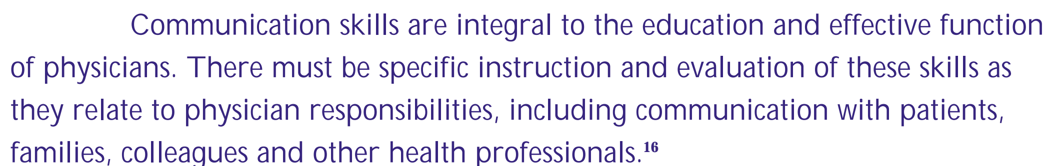
based records, telemedicine) are rapidly becoming commonplace, broadening the scope of relevant communication skills further to include information management. While this paper will focus on physician-patient communication, it will raise issues relevant to these other areas as well.

Regarding the familiar triad of knowledge, attitudes and skills: When it comes to teaching and assessing communication in the context of medical education, the primary emphasis is on skills. The focus on skills, in and of itself, suggests that communication can be taught, learned and improved. However, the work on skills needs to be placed in context. Knowledge of several basic interpersonal communication concepts (e.g., direct and indirect messages; types and functions of nonverbal communication) provides essential background and vocabulary for thinking about and practicing these skills. Relevant attitudes include appreciating the importance of effective communication, the need to see patients as people rather than as cases, and the contribution of different players on the health-care team.

The Importance of Effective Communication in Medicine

There is solid science behind what many refer to as the "art of medicine." Research published in the late 1960s by Barbara Korsch and her colleagues is widely considered the foundation for inquiry into the physician-patient relationship.[7,8] In a large, diverse number of studies since then, effective communication has been linked with increases in physician and patient satisfaction, adherence to treatment plans, more appropriate medical decisions and better health outcomes.[9,10] More recently, research has revealed a relationship between effective communication and decreased incidence of malpractice claims against primary care physicians.[11] In addition, surveys indicate that most people get most of their information about health and medicine from physicians.[12,13] Thus, it is clear that the AAMC's 1984 GPEP and 1993 ACME-TRI reports' calls for focusing on physician-patient communication skills teaching and assessment in undergraduate medical education were well grounded.[14,15]

Attention to communication skills in North American medical schools is likely to increase, given a resolution adopted in 1995 by the Liaison Committee on Medical Education (LCME) and the Committee on Accreditation of Canadian Medical Schools (CACMS):



Communication skills are integral to the education and effective function of physicians. There must be specific instruction and evaluation of these skills as they relate to physician responsibilities, including communication with patients, families, colleagues and other health professionals.[16]

This resolution suggests not simply an opportunity, but a responsibility, for medical schools to teach and assess communication skills. However, it is important to note that similar calls issued in the past did not generate a great deal of curricular change. For instance, the GPEP Subgroup Report on Clinical Skills issued a very straightforward statement:

The theory and practice of communication skills need systematic attention. The knowledge base of communication should be included in the medical curriculum. Interviewing skills should be taught and evaluated. Every effort should be directed at developing and enhancing a patient-centered, humanistic attitude in medical students.[14]

While the LCME/CACMS resolution is likely to have more of an effect, given its link to accreditation, it is clear that the process of curricular change takes time, and that the product must be carefully evaluated.[17] Indeed, studies indicate tremendous variation in the way, and extent to which, communication skills are taught and assessed in medical schools, both in the United States and the United Kingdom.[18,19]

The Current State of Communication Skills and Assessment

To determine the status of communication skills teaching and assessment in North America, the Association of American Medical Colleges (AAMC) distributed a two-stage survey to all 141 accredited medical schools in Canada, Puerto Rico, and the United States, one of which has four campuses, bringing the total number of surveys to 144. The first stage of the survey, which was distributed in 1997 to associate deans responsible for medical education, was designed to collect information on whether and when communication skills were taught and assessed. The second stage, distributed in 1998, asked the associate deans to provide more detail regarding basic communication skills, as well as communication education related to end-of-life care, cultural sensitivity, spirituality, and family violence. Both

surveys were conducted in cooperation with the Program in Communication & Medicine at Northwestern University Medical School.

Associate deans at 99 of the 144 schools (68.8%) responded to the detailed second-stage survey. An additional 16 schools (11.1%) provided responses to the first-stage survey, yielding an overall response from 115 of the 144 schools (79.9%) for questions regarding the timing of basic communication skills teaching and assessment. Notes to the figures and tables in this paper specify the number of respondents upon which they are based.

Only five of the 115 schools that provided responses to questions about basic communication skills reported that they do not teach communication beyond history taking; an additional three reported that they do not assess communication skills. Figure 1 illustrates the timing of teaching and assessment for the 110 schools that reported teaching communication skills at some point within their curricula.

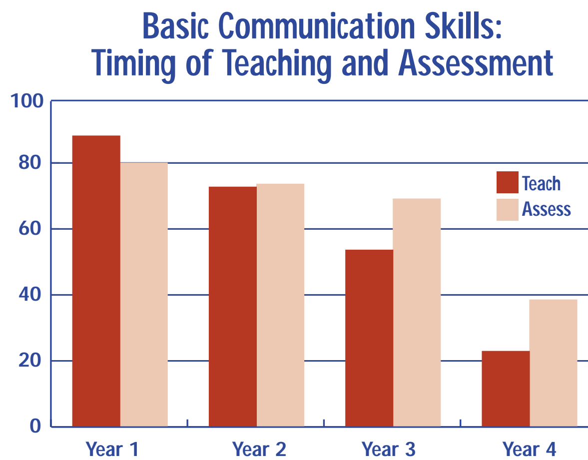


Table 1 provides an overview of the diverse teaching methods used regarding communication skills. A considerable majority (85.4%) of the 89 schools responding to this part of the survey reported that they employ a combination of discussion, observation, and practice. In order of frequency, the primary teaching methods appear to be small-group discussions and seminars, lectures and presentations, student interviews with simulated patients, student observation of faculty with real patients, and student interviews with real patients. Nearly half of the schools (44.9%) reported using rounds to teach communication skills. Rounds offer an excellent opportunity for combining communication skills teaching with clinical experience, but without a framework to help structure and focus attention on communication, the teaching is likely to be inconsistent and ineffective. While video-

tapes of student interactions provide powerful material for reflection and self-assessment, the logistical difficulties of implementing a videotaping system are evident in the table: Only 40.4% of the 89 schools reported using this teaching method.

Table 2 summarizes assessment methods currently in place. Almost all of the 92 schools responding to this portion of the survey reported assessing students' communication skills through faculty feedback during teaching sessions. More objective assessment methods, such as those involving simulated (i.e., standardized) patients are less widespread. Again, the reliability and effectiveness of observation and feedback, regardless of the particular method, are likely to be compromised unless they are grounded in a coherent framework.

This point merits attention. While schools are using a variety of teaching and assessment methods, there is an apparent lack of structure to these activities. As shown in Figure 2, just 30 of 95 medical schools (31.6%) reported integrating a model or framework into teaching, and 30 reported using such a structure for

Table 1
Methods for Teaching Basic Communication Skills

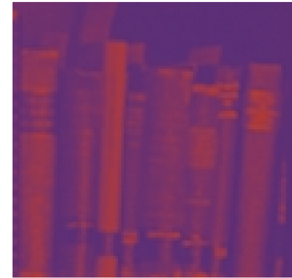
Teaching Methods in Use	(% of 89 schools reporting)
Small-group discussions/seminars	91.0
Lectures/presentations	82.0
Student interviews with simulated patients	78.7
Student observations of faculty with real patients	74.2
Student interviews with real patients	71.9
Role-playing with peers	59.6
Rounds	44.9
Video trigger tapes for discussion	42.7
Videotapes of student interactions	40.4
Instructional videotapes	30.3
Required attendance at community activities	23.6
Journals (i.e., written reflections)	19.1
Patient advocacy	13.5
Story telling by students	13.5
Story telling by patients (i.e., patient narrative)	10.1

* Of the 110 North American medical schools that reported teaching basic communication skills at some point within their curricula, 89 completed the second-stage survey section on teaching methods. The percentages in this table are based on responses from those 89 institutions. Teaching methods are listed if at least 5% of the respondents in this sample reported using them.

Table 2
Methods of Assessing Basic Communication Skills*

Assessment Methods in Use	(% of 92 schools reporting)
Faculty feedback during teaching sessions	92.4
Formalized faculty observation of students	78.3
Patient or simulated patient feedback	76.1
Assessment with simulated patients (i.e., OSCE)	69.6
Student self-assessment with video	38.0
Peer assessment	38.0
Multiple-choice examinations	34.8
Formalized feedback from nurses, PAs, etc.	23.9
Essay/written examinations	22.8
Student self-assessment without video	20.7

*Of the 110 North American medical schools that reported teaching basic communication skills at some point within their curricula, 107 reported assessing communication, 92 of which competed the second-stage survey section on assessment methods. The percentages in this table are based on responses from those 92 institutions. Assessment methods are listed if at least 5% of the respondents in this sample reported using them.



assessment. Only 22 of these schools used a framework for both teaching and assessment. Of the schools using a model, most use either the SEGUE Framework for Teaching and Assessing Communication Skills (10 for teaching and 16 for assessment)[20] or the Calgary-Cambridge Observation Guide (7 for teaching and 5 for assessment).[21]

Figure 2
Use of Frameworks for Teaching and Assessment*

		TEACHING	
		No	Yes
ASSESSMENT	No	57	8
	Yes	8	22

* Of the 110 North American medical schools that reported teaching basic communication skills at some point within their curricula, 95 completed the second-stage survey sections on teaching and assessment models. The percentages in this table are based on responses from those 95 institutions.

At the recent Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education, communication experts and representatives from associations involved in medical education reached consensus on the benefit of using a framework as a foundation for teaching and assessment activities. This group expects to release a consensus statement based on an analysis of common elements amongst established models, which should offer a tangible and timely resource for medical schools and residency programs.

An Action Plan for Improving Communication Skills Education

This action plan is designed to stimulate ideas and initiatives for more effective communication skills teaching and assessment. After offering a broad perspective on communication skills education in the form of an international consensus statement, this plan provides a sampling of institutional-level goals and objectives, as well as a brief discussion of teaching and assessment strategies.

Consensus Statement

Great interest in improving communication skills education was evident at the 1996 Teaching about Communication in Medicine Conference, which was attended by 200 people from 21 different countries. This conference provided a forum for people involved in teaching and assessing communication skills in undergraduate or graduate medical education to share ideas and research about their work. In the final workshop of the conference, 25 of the participants, representing medical schools in Canada, the United Kingdom, the United States, and several other countries, met to determine if a consensus could be reached on key issues raised in the conference. The points were refined in subsequent discussions with other interested groups such as the AAMC, and endorsed in their current form during a workshop of 22 faculty members who attended the 1998 Amsterdam Conference on Communication in Health Care. An annotated outline of the consensus statement follows (adapted, with permission, from *Patient Education & Counseling*).[22]

1. *Teaching and assessment should be based on a broad view of communication in medicine.* Education about doctor-patient communication should include not only the development of relevant skills, but also an understanding of the nature, context and ethics of the doctor-patient relationship. The scope of teaching should encompass communication with families and professional colleagues, as well as written and oral presentation skills and use of the telephone in medicine. Teaching and assessment should be informed by the evidence base for effective communication, which can be found in both clinical and behavioral science literature.[9,23]

2. *Communication skills teaching and clinical teaching should be consistent and complementary.* Communication skills teaching and clinical experiences often occur at different times during medical education. This can diminish the relevance of communication education and, thus, the value that students place on it. Students may be exposed to very mixed messages such as being expected to "take histories" and ask specific questions by their clinical teachers, but to ask open questions and be reflective by those teaching communication. It is particularly important that the clinicians with whom students work are aware of, reinforce, and exemplify the key messages of communication skills teaching. Similarly, it is imperative that communication faculty create educational experiences that are highly relevant to clinical work.

3. *Teaching should define, and help students achieve, patient-centered communication tasks.* The framework for teaching should emphasize the tasks that enable doctors to meet the needs of their patients. These tasks should be patient-centered,[24] integrating knowledge of the medical problem with an appreciation of the patient's illness experience, and meeting the patient's needs for information, involvement and care. Focusing on tasks provides a sense of purpose for learning communication skills.[25] The task approach also preserves the individuality of students by encouraging them to develop a repertoire of strategies and skills, and respond to patients in a flexible way. For example, if one task is defined as "establishing the patient's principal concerns," the student can proceed in a variety of equally effective ways, choosing one tailored to the patient and situation. This flexible approach reflects the reality of both medical practice and human communication.

4. *Communication teaching and assessment should foster personal and professional growth.* Working in medicine can be demanding, distressing, and even damaging to the health of the doctor. Students should have the opportunity to learn how to develop self-awareness and learn appropriate coping strategies. With careful planning, this type of activity can take place in small-group discussions. In addition, methods used for feedback should encourage students to reflect on their strengths and identify areas in which they can improve their competence. Teaching and assessment that responds to the needs of learners is likely to foster medical care that responds to the needs of patients.[17,26]

5. *There should be a planned and coherent framework for communication skills teaching.* Each medical school needs a curriculum for communication skills teaching that states clear goals and objectives for the knowledge, skills and attitudes students will achieve; a coherent structure for teaching and learning; and a description of how the education is related to students' needs and experiences at the time. This plan should enable key messages to be developed and reinforced at appropriate stages of medical education. The plan must be part of the overall curriculum of each individual medical school. Teachers of medical ethics in the United Kingdom have found it helpful to work together in developing a list of key topics that can be used as a basis for discussion and development of individual programs.[27] Communication skills teachers might find this approach useful as well.

6. *Students' ability to achieve communication tasks should be assessed directly.*

Medical students' ability to communicate is often assessed indirectly, via presentation of information they have obtained from a patient. This process could be enhanced if students were routinely asked not only about histories and differential diagnoses, but also about their patients' knowledge and concerns about their health problems, how the problems affect their lives, and their expectations of medical care. Communication is a key component of clinical competence and should also be assessed by direct observation. Reliable and valid instruments have been developed[28] and, after appropriate training for the assessors, should be included as an integral part of the assessment of clinical skills. This would send a powerful message to students about the importance that medical schools place on communication with patients. Such assessments also offer an opportunity to provide students with constructive feedback and to respond remedially when students perform poorly.

7. *Communication skills teaching and assessment programs should be evaluated.*

Communication skills teaching and assessment in each medical school requires continuous evaluation to ensure that activities are being implemented as planned, and that they relate to one another. Beyond issues of quality control and improvement, evaluation should be considered a quid pro quo for any investment of curriculum time and resources. This focus on careful evaluation will also help to establish the long-term effects of different approaches to teaching on performance in practice.

8. *Faculty development should be supported and adequately resourced.*

Teaching communication in medicine involves understanding the relevant underlying concepts and the use of specific skills, such as facilitating groups and giving feedback. These skills may not be familiar to practicing clinicians, and while successful national courses have been developed,[29,30,31] time and resources for teacher development should be available at the local level as well. There is often a single teacher in a medical school responsible for designing programs and developing teachers in communication skills. This person can benefit greatly from sharing ideas and experiences with colleagues in other disciplines as well as those in other medical schools. Faculty involved in teaching and assessment need to feel that their efforts are supported and valued, particularly in the face of competing claims on their own and their students' time.

Institutional Goals and Objectives

One aspect of positioning communication as a fundamental clinical skill is to articulate specific goals and objectives. While this is important at the institutional, course, and session levels, the focus here is on providing examples of institutional goals and objectives that outline what a medical student should know or be able to demonstrate by the time of graduation. In order to emphasize a stage-appropriate progression, two sets of goals and objectives are presented: one for the first two years, and one for the second two years. Since each institution must determine and tailor its own goals and objectives, the following sets should be taken as illustrative; they are neither exhaustive nor prescriptive.

Years One and Two

Goal 1: Develop an appreciation of the interpersonal and situational dynamics of medical encounters.

Different patients and different encounter settings will greatly influence the way students envision — and are able to effect — their roles and goals in patient care. It is essential that students explore the interdependence between themselves, their patients and their environment. Understanding basic interpersonal communication processes, gaining a sensitivity to patient perspectives and developing a sense of personal awareness are the foundations of this exploration.

Objectives

Knowledge: Students should demonstrate an understanding of basic interpersonal communication concepts and processes (e.g., communication models, verbal and non-verbal communication, attribution).

Students should demonstrate an understanding of the meaning of, and rationale for, patient-centered medicine.

Attitudes: Students should demonstrate a sensitivity to patient perspectives.

Students should demonstrate a sensitivity to cultural and personal factors that might influence their interactions with patients.

Goal 2: Become oriented to the communication tasks of a physician.

Students are likely to derive the most benefit from communication skills instruction if it is tied to clinical practice in a clear and stage-appropriate manner. Thus, students can be introduced to a model outlining the communication tasks that physicians strive to accomplish, and proceed to work on the tasks most relevant to their level of training.

Objectives

Knowledge: Students should be able to delineate communication tasks that are integral to effective and efficient medical encounters. There are several well established models that highlight core competencies, including the Brown Interview Checklist,[32] the Calgary-Cambridge Observation Guide,[21] the E4 Model,[33] the Patient-Centered Clinical Method,[24] and the SEGUE Framework for Teaching and Assessing Communication Skills.[20] For instance, the SEGUE Framework includes 25 specific communication tasks: (There is a longer form of the SEGUE Framework, which also includes tasks relevant to discussion of new or modified treatment/lifestyle plans.)

Set the Stage

- Greet the patient appropriately
- Establish the reason for visit
- Outline the agenda for visit
- Make a personal connection
- Maintain privacy

Elicit Information

- Elicit the patient's view of health problem and/or progress
- Explore physical/physiological factors
- Explore psychosocial/emotional factors
- Discuss antecedent treatments
- Discuss how health problem affects the patient's life
- Discuss lifestyle issues/prevention strategies/health risks
- Avoid directive/leading questions
- Give the patient opportunity/time to talk
- Listen. Give the patient undivided attention
- Check/clarify information

Give Information

Explain rationale for diagnostic procedures
Teach the patient about his/her own body & situation
Encourage the patient to ask questions
Adapt to the patient's level of understanding

Understand the Patient's Perspective

Acknowledge the patient's accomplishments/progress/challenges
Acknowledge waiting time
Express caring, concern, empathy
Maintain a respectful tone

End the Encounter

Ask if there is anything else the patient would like to discuss
Review next steps with the patient

Attitudes: Students should either demonstrate the belief that such communication tasks are integral to effective and efficient medical encounters, or be able to articulate an argument that some tasks may not be applicable in a particular clinical context.

Goal 3: Begin to build a base of skills and strategies associated with these tasks.

The bulk of instruction will entail helping students gain and/or improve communication skills that will help them achieve communication tasks. Skill-building entails a combination of reading, discussion, reflection, practice and feedback. Ample opportunities for these learning activities are absolutely critical.

Objectives

Knowledge: Students should be able to demonstrate an understanding of the place and purpose of basic communication skills and strategies (e.g., asking open-ended questions, using silence, reflecting patients' comments).

Students should be able to delineate which communication skills and strategies can be utilized to accomplish particular communication tasks (e.g., using silence as a way to elicit the patient's view of his or her health problem).

<u>Attitudes</u>: Students should demonstrate the belief that communication skills can be learned and improved.

Students should take seriously any opportunities they are given for practicing communication skills, whether role-play with each other, work with patient instructors or interactions with real patients.

<u>Skills</u>: Students should demonstrate proficiency in using a number of different skills and strategies to accomplish the communication tasks. In other words, students should not approach their patients in a rigid, highly scripted manner.

Years Three and Four

Goal 1: Begin to learn how to deal with difficult topics and situations encountered in clinical practice.

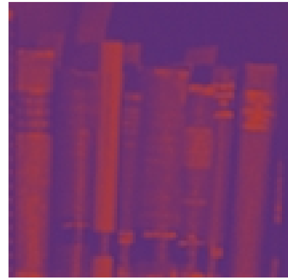
Given the range of patient-physician encounters, all students have skills and situations that particularly interest or worry them (e.g., dealing with dying patients, dealing with angry patients, delivering bad news). While students may not be expected to master these more advanced skills and situations early in their medical training, they should be provided with the time and opportunity for exploration and practice in these areas.

Objectives

<u>Knowledge</u>: After relevant reading and/or instruction, students should be able to generate a list of skills and strategies that might be appropriate for a given difficult situation (e.g., when breaking bad news: be direct, avoid jargon, clarify statements, acknowledge reaction of patient and/or family members).

<u>Attitudes</u>: Students should demonstrate a commitment to learning about difficult topics and situations.

<u>Skills</u>: Students should demonstrate proficiency in dealing with difficult situations. More specifically, they should be able to avoid escalating or obfuscating a difficult encounter. In addition, after a difficult encounter, they should be able to identify the skills and strategies they utilized and suggest what worked well and what they might have done differently.



Goal 2: Develop a base of skills and strategies for working with family members.

While the first two years focus on communication with patients, it is important to broaden that focus in Years Three and Four to include communication with families. Students will be seeing patients' family members during clerkship rotations, which will reinforce the relevance of learning to provide and elicit information from families.

Objectives

Knowledge: After relevant reading and/or instruction, students should demonstrate an understanding of how family members can influence health outcomes through instrumental support, social support and patient advocacy, or the lack thereof.

Attitudes: Students should demonstrate a sensitivity to the uncertainty and anxiety that members of patients' families experience.

Skills: Students should be able to appropriately involve family members who accompany patients to physician visits.

Students should be able to effectively handle questions from family members who act as caregivers. At this stage in students' training, the key is to make proper judgments about which questions are appropriate to answer and which should be directed to another member of the health-care team.

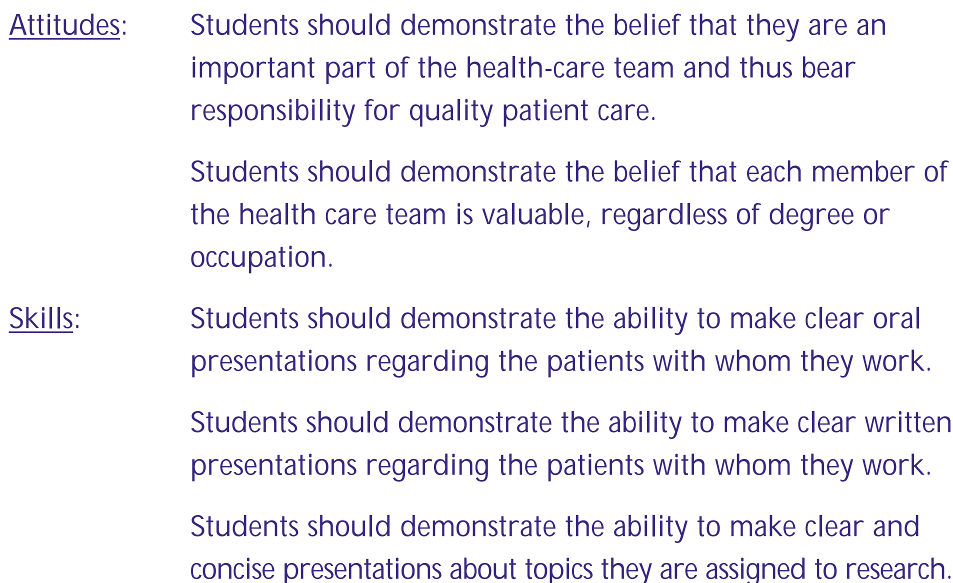
Goal 3: Develop a base of skills and strategies for working with physician colleagues and other members of the health-care team.

Whereas students may have been working in ambulatory or hospital settings during their first two years, it is not until the clerkships that they begin to be seen as a member of the health-care team. It is essential that they be provided with an early introduction to the importance of clear communication with team members and start to develop skills and strategies in areas such as conflict management.

Objectives

Knowledge: After relevant reading and/or instruction, students should be able to outline the roles and goals of health-care team members.

After relevant reading and/or instruction, students should be able to outline strategies for conflict management and resolution.



Attitudes: Students should demonstrate the belief that they are an important part of the health-care team and thus bear responsibility for quality patient care.

Students should demonstrate the belief that each member of the health care team is valuable, regardless of degree or occupation.

Skills: Students should demonstrate the ability to make clear oral presentations regarding the patients with whom they work.

Students should demonstrate the ability to make clear written presentations regarding the patients with whom they work.

Students should demonstrate the ability to make clear and concise presentations about topics they are assigned to research.

Teaching Strategies

While the key to learning any skill is practice, it is important that students also be provided with context for building their communication skills via an introduction to communication concepts and an explication of communication tasks. This knowledge provides a foundation for practice, review and reflection, allowing students to move beyond a mechanized approach to skill building. A model or framework that outlines key communication tasks can provide a coherent and useful underlying structure for teaching, provided that the framework is seen as an organizational guide and not a rigid script. In other words, since a variety of communication skills and strategies are relevant to each task, teachers should encourage learners to explore and develop different approaches. Further, rather than telling students why effective communication skills are important or useful, it is essential to have them discuss and debate these issues. Again, this decreases the sense of "going through the motions," and facilitates integration of associated knowledge, attitudes and skills.

Two tools are especially useful in the first two years of medical school: (1) role-playing, with trained patient instructors, faculty or other students; (2) videotape. Role-playing allows students to practice their skills and receive immediate, constructive feedback, while videotape is a powerful trigger for review and reflection. Once students start seeing real patients — whether in early preceptorships, more traditional Physical Diagnosis or Introduction to Clinical Medicine courses, or the clerkships

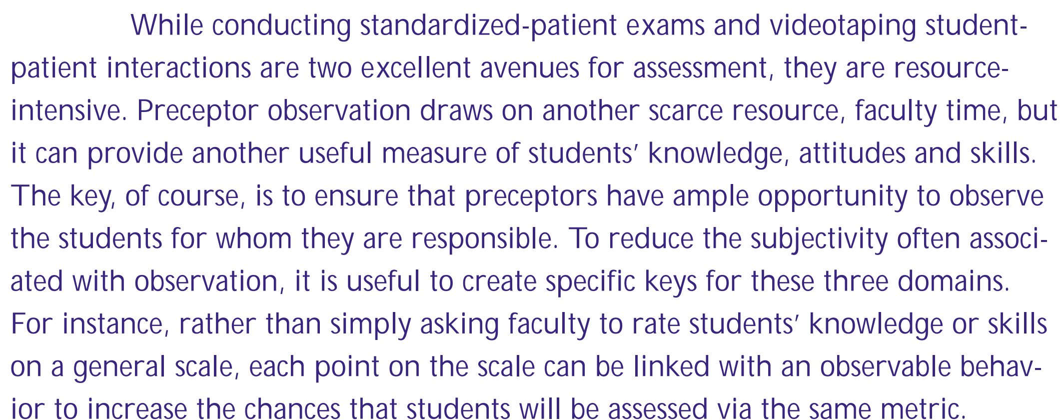
— it is important that the physician with whom they are working observes them with patients, families and members of the health-care team, and provides timely feedback regarding communication. It is the interplay between practice and feedback that leads to progress in developing and broadening communication skills. The cycle of practice, feedback and reflection is integral to the interrelated domains of skills development and personal awareness.[21,26,34]

There are several well established programs for communication teaching and learning in medical schools. The most successful efforts in years one and two will: (1) make a point of providing a conceptual context and coherent framework for learning skills; (2) address a broad range of communication tasks; (3) encourage students to explore higher-order skills and difficult situations in a learner-centered fashion. In years three and four, it is essential that preceptors are aware of the form and content of students' previous training so they can reinforce key messages, skills and strategies. This continuity can be enhanced by simply sharing information, as well as through faculty development efforts such as train-the-trainer sessions.

Assessment Strategies

While creative exams and evaluations of class discussion can be used to assess knowledge and attitudes, the increasingly vigorous calls for improving physician-patient communication coincide with increasingly rigorous attempts to assess students' clinical skills. There is a growing movement toward testing clinical skills by having medical students interact with standardized patients, people trained to role-play patients and note student performance.[35] The term standardized warrants emphasis, since the patients are, in effect, the test. Thus, truly standardized patients are trained to enact the same patient role — with the same demeanor and same information content — during each student encounter. They are also trained to use consistent criteria for evaluating each student, which reinforces the benefit of integrating a framework into both teaching and assessment activities.

In general, after an encounter, the student leaves the room, and the standardized patient completes a report regarding that student's performance. Videotape is an essential component of standardized-patient exams, as it can be used both for feedback and to determine interrater reliability. Even if videotaping is not feasible, medical educators would do well to remember that assessments can serve as both summative and formative evaluations, providing opportunities for feedback beyond score reports whenever possible and appropriate. For example, students can learn by watching their videotaped encounters or by receiving narrative comments.



While conducting standardized-patient exams and videotaping student-patient interactions are two excellent avenues for assessment, they are resource-intensive. Preceptor observation draws on another scarce resource, faculty time, but it can provide another useful measure of students' knowledge, attitudes and skills. The key, of course, is to ensure that preceptors have ample opportunity to observe the students for whom they are responsible. To reduce the subjectivity often associated with observation, it is useful to create specific keys for these three domains. For instance, rather than simply asking faculty to rate students' knowledge or skills on a general scale, each point on the scale can be linked with an observable behavior to increase the chances that students will be assessed via the same metric.

Conclusion

If undergraduate medical education is to provide a solid foundation in communication skills, there is a need to move toward a more active exchange of information and methods among medical schools, along with a real commitment to faculty development. As illustrated by response to the Communication in Medicine Conference series, there is widespread interest in such an exchange and increased opportunity for faculty development. Attention to the structural elements of goals, objectives and frameworks will increase the coherence and consistency of communication skills teaching and assessment, increasing quality while fostering creative approaches to implementation. Medical schools that act on recommendations, resolutions, and consensus statements regarding communication skills are doing much more than fulfilling a new LCME/CACMS requirement and preparing their students for board exams; these institutions are meeting an important obligation to students and, ultimately, the patients they will serve.

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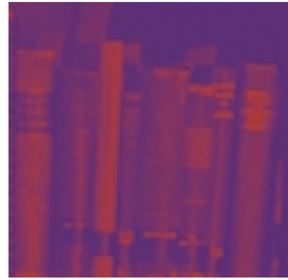

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Task Force Report

Spirituality, Cultural Issues, and End of Life Care

Introduction

The Task Force on Spirituality, Cultural Issues, and End of Life Care was sponsored by the National Institute for Healthcare Research (NIHR), with a grant from the John Templeton Foundation. NIHR is a private, non-profit organization dedicated to advancing the study of under- recognized factors that promote or negatively impact on physical or mental health. The Task Force was composed primarily of individuals involved in curriculum management or reform at several medical schools, with staff support provided by the AAMC's Division of Medical Education (the Task Force members are identified at the end of the Report). The Task Force was charged with developing detailed learning objectives relevant to the topics of concern, and suggesting learning strategies that deans and faculties might employ in their educational programs to enable students to achieve the stated objectives.

In preparing MSOP Report III, the AAMC staff reviewed the Task Force's work, and decided to include sections of the Task Force's Report in this report (MSOP III). In order to provide a context for the content set forth below, it is important to recognize that there are more than 50 medical schools that now offer courses or course content on topics such as spirituality in medicine, cross cultural sensitivity/awareness, and end-of-life care. Because communication about these sensitive topics is so critical to developing an effective doctor-patient relationship in some circumstances, it seems appropriate to place special emphasis on them in this report.

Definitions

The following definitions were agreed upon by the Task Force members and were used to guide them in the course of pursuing the Task Force charge:

Health is not just absence of disease, but a state of well-being that includes a sense that life has purpose and meaning. The Pew – Fetzer definition of health is:

We are coming to understand health not as the absence of disease, but rather as the process by which individuals maintain their sense of coherence (i.e. sense that life is comprehensible, manageable and meaningful) and ability to function in the face of changes in themselves and their relationship with the environment (Antonovsky, 1987).

Spirituality is recognized as a factor that contributes to health in many persons. The concept of spirituality is found in all cultures and societies. It is expressed in an individual's search for ultimate meaning through participation in religion and/or belief in God, family, naturalism, rationalism, humanism, and the arts. All of these factors can influence how patients and health care professionals perceive health and illness and how they interact with one another.

Culture is defined by each person in relationship to the group or groups with whom he or she identifies. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choices. Cultural identity may be affected by such factors as race, ethnicity, age, language, country of origin, acculturation, sexual orientation, gender, socioeconomic status, religious/spiritual beliefs, physical abilities, and occupation, among others. These factors may impact behaviors such as communication styles, diet preferences, health beliefs, family roles, lifestyle, rituals, and decision-making processes. All of these beliefs and practices, in turn, can influence how patients and health care professionals perceive health and illness and how they interact with one another.

End-of-Life refers to the part of the life cycle when the possibility of death becomes a major concern for the patient and his or her family, and for the physician. End-of-life issues are those that the individual person faces when he or she is confronted with a condition in which dying is a distinct possibility. There is no clear demarcation between active treatment of an illness and the end of life. Rather, end–of-life refers to the entire time, even during treatment of an illness when dying becomes an important consideration. Both a person's spirituality and culture may affect significantly his or her beliefs, attitudes, and behaviors toward end-of-life health care interventions.

Outcome Goals

Students will be aware that spirituality, and cultural beliefs and practices, are important elements of the health and well being of many patients. They will be aware of the need to incorporate awareness of spirituality, and culture beliefs and practices, into the care of patients in a variety of clinical contexts. They will recognize that their own spirituality, and cultural beliefs and practices, might affect the ways they relate to, and provide care to, patients.

Students will be aware of the range of end-of-life care issues and when such issues have or should become a focus for the patient, the patient's family, and members of the health care team involved in the care of the patient. They will be aware

of the need to respond not only to the physical needs that occur at the end of life, but also the emotional, socio-cultural, and spiritual needs that occur.

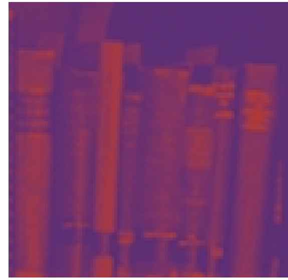
Learning Objectives

With regard to *spirituality* and *cultural issues*, before graduation students will have demonstrated to the satisfaction of the faculty:

- The ability to elicit a spiritual history
- The ability to obtain a cultural history that elicits the patient's cultural identity, experiences and explanations of illness, self-selected health practices, culturally relevant interpretations of social stress factors, and availability of culturally relevant support systems
- An understanding that the spiritual dimension of people's lives is an avenue for compassionate care giving
- The ability to apply the understanding of a patient's spirituality and cultural beliefs and behaviors to appropriate clinical contexts (e.g., in prevention, case formulation, treatment planning, challenging clinical situations)
- Knowledge of research data on the impact of spirituality on health and on health care outcomes, and on the impact of patients' cultural identity, beliefs, and practices on their health, access to and interactions with health care providers, and health outcomes
- An understanding of, and respect for, the role of clergy and other spiritual leaders, and culturally-based healers and care providers, and how to communicate and/or collaborate with them on behalf of patients' physical and/or spiritual needs
- An understanding of their own spirituality and how it can be nurtured as part of their professional growth, promotion of their well-being, and the basis of their calling as a physician

With regard to *end-of-life care issues*, before graduation, students will have demonstrated to the satisfaction of the faculty:

- An understanding that death is a natural part of life, that suffering and loss are an integral part of the human life cycle, and that the physician's role encompasses the comprehensive care of the patient and their family during the entire transition between life and death

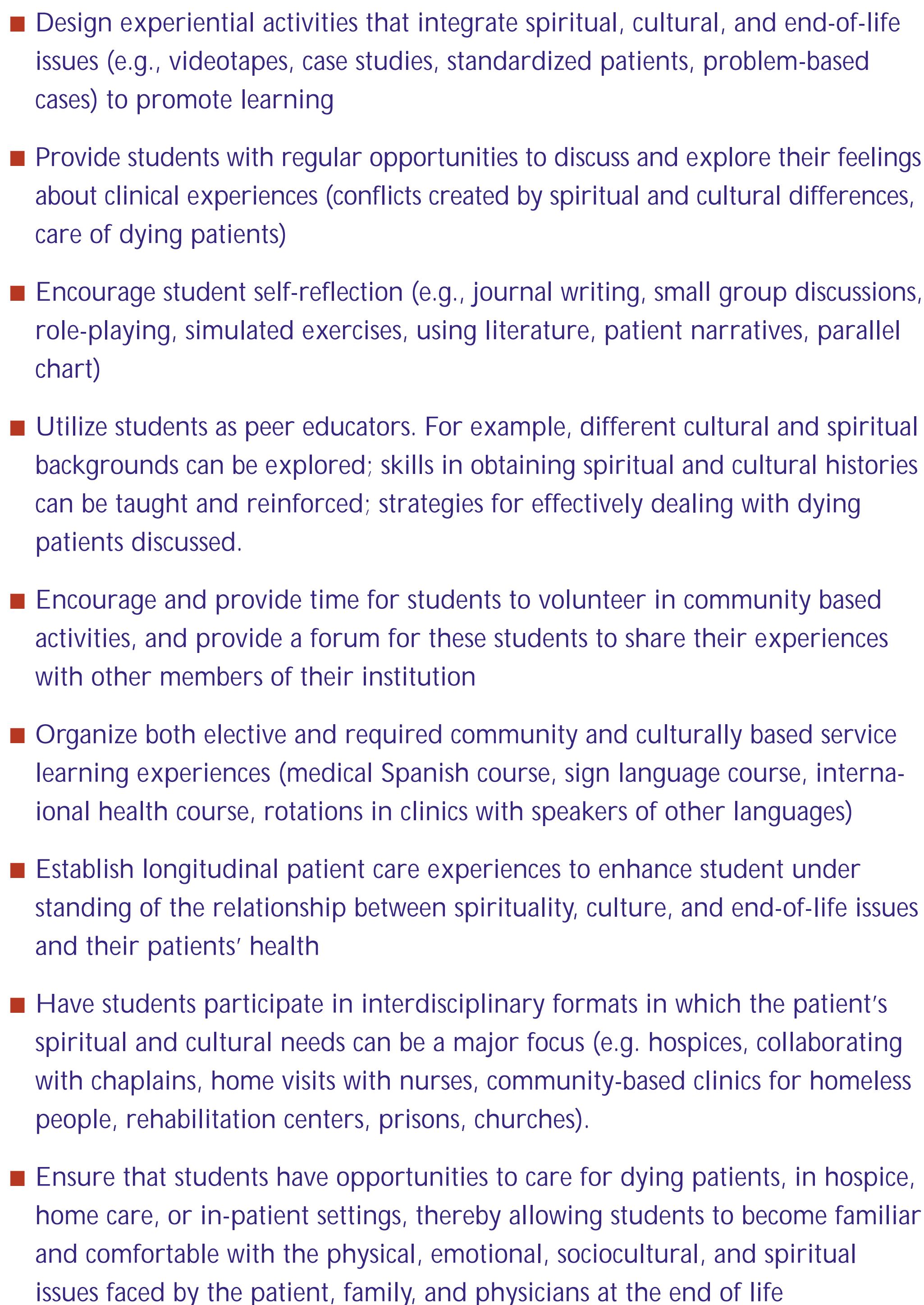


- The ability to deliver difficult news about end-of-life issues to patients and their families in a caring and compassionate manner; to elicit patients' values, beliefs, and preferences for treatment at the end of life; to obtain advance directives and knowledge of surrogate issues
- Recognize that when death becomes a likely possibility, treatment options may change depending on the risks and benefits of a particular treatment, the con sequences of that treatment for the patient and patient preference for type of care.
- An understanding that the concept of palliative care refers to all of the dimensions of care (physical, emotional, social and spiritual) that should be provided at the end of life
- The ability to recognize the spectrum of the physical, emotional, sociocultural, and spiritual symptoms of distress patients may exhibit at the end of life, and the appropriate ways to respond to them
- The ability to work with, and value, a multi-disciplinary team delivering end-of-life care, and to communicate effectively both orally and in writing with colleagues and other health care providers in order to deliver appropriate care to patients at the end of life
- The ability to access data on end-of-life issues and utilize these data in the case formulations and management plans of patients at the end of life

Educational Strategies

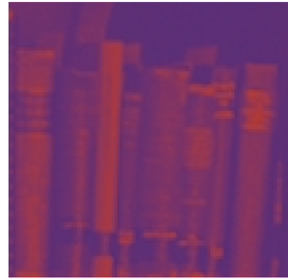
Listed below are suggestions for strategies that might be employed by deans and faculties to ensure that their students have learning experiences that will allow them to achieve the objectives set forth above.

- Develop specific learning objectives relating to each of the three topics (spirituality, cultural issues, and end-of-life care)
- Develop educational resources designed to accomplish learning objectives
- Establish a curriculum management process that insures that relevant issues are included in all four years of the curriculum, incorporating content into existing courses wherever possible.
- Design educational experiences so that students learn how to elicit a spiritual and cultural history, and talk to dying patients



- Design experiential activities that integrate spiritual, cultural, and end-of-life issues (e.g., videotapes, case studies, standardized patients, problem-based cases) to promote learning
- Provide students with regular opportunities to discuss and explore their feelings about clinical experiences (conflicts created by spiritual and cultural differences, care of dying patients)
- Encourage student self-reflection (e.g., journal writing, small group discussions, role-playing, simulated exercises, using literature, patient narratives, parallel chart)
- Utilize students as peer educators. For example, different cultural and spiritual backgrounds can be explored; skills in obtaining spiritual and cultural histories can be taught and reinforced; strategies for effectively dealing with dying patients discussed.
- Encourage and provide time for students to volunteer in community based activities, and provide a forum for these students to share their experiences with other members of their institution
- Organize both elective and required community and culturally based service learning experiences (medical Spanish course, sign language course, interna-ional health course, rotations in clinics with speakers of other languages)
- Establish longitudinal patient care experiences to enhance student under standing of the relationship between spirituality, culture, and end-of-life issues and their patients' health
- Have students participate in interdisciplinary formats in which the patient's spiritual and cultural needs can be a major focus (e.g. hospices, collaborating with chaplains, home visits with nurses, community-based clinics for homeless people, rehabilitation centers, prisons, churches).
- Ensure that students have opportunities to care for dying patients, in hospice, home care, or in-patient settings, thereby allowing students to become familiar and comfortable with the physical, emotional, sociocultural, and spiritual issues faced by the patient, family, and physicians at the end of life

Task Force Members



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