Communication skills education for doctors: an update

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Editorial board

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The board of medical education has a long standing interest in communication skills. In January 2003 it released its publication *Communication skills education for doctors: a discussion paper*. On issuing the report, the board invited feedback in order to stimulate debate among the profession. It received responses from 22 external organisations and BMA committees.

In general, the responses received were positive and supported the paper’s key messages regarding the importance of communication skills. Many of the responses also offered suggestions for improving and expanding the report. Since 2003 significant progress has been made on the communication skills agenda for doctors and other healthcare professionals.

This update is built around the structure of the BMA’s original discussion paper. However, it also incorporates the feedback received from external organisations and BMA committees and includes reference to some of the more recent developments in this field.

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1 Publications by the Board of Medical Education: *Communication skills and continuing professional development* (1998) and *Communication skills education for doctors: a discussion paper* (2003)
Good communication skills are integral to medical and other healthcare practice. Communication is important not only to professional-patient interaction but also within the healthcare team. The benefits of effective communication include good working relationships and increased patient satisfaction. Effective communication may increase patient understanding of treatment, improve compliance and, in some cases, lead to improved health. It can also make the professional-patient relationship a more equitable one. Undoubtedly however, there are barriers to effective communication ranging from personal attitudes to the limitations placed on doctors by the organisational structures in which they work.

In order to deliver effective healthcare, doctors are expected to communicate competently both orally and in writing with a range of professionals, managers, patients, families and carers. Simply recognising the need for good communication skills is not enough; healthcare professionals must actively strive to achieve good communication skills by evaluating their own abilities. Education providers need to ensure that appropriate and effective training opportunities are available to doctors to develop and refine such skills in order to facilitate interaction with patients and others.

Although this paper focuses on communication skills in the clinical context, doctors need communication skills in a wide range of different contexts. For example, communication skills are necessary to present evidence in court, to communicate research findings, to write more generally for journals and magazines, and to talk to the media. As a profession, doctors’ communication skills help to determine how medicine is presented to the public and to the legislature.
This paper aims to raise awareness among the medical profession of the significant issues involved in communication skills training at both undergraduate and postgraduate level. The paper highlights:

- the benefits of good communication skills
- the concerns expressed about inadequate communication skills in the medical profession
- barriers to effective communication
- communication skills in undergraduate and postgraduate education.

Although this paper focuses on doctors, many of its principles are applicable to other healthcare workers.
Communicating with patients, their relatives and carers

Good communication engenders meaningful and trusting relationships between healthcare professionals and their patients. This is accepted as fundamental to effective patient care.\(^1\) Kurtz\(^2\) outlines five principles of effective communication:

**Principles of effective communication**

- ensures interaction rather than direct transmission
- reduces unnecessary uncertainty
- requires planning and thinking in terms of outcomes
- demonstrates dynamism – what is appropriate for one situation is inappropriate for another. Achieving this dynamism requires flexibility, responsiveness and involvement
- follows the helical model (what one person says influences what the other says in a spiral fashion so that communication gradually evolves through interaction).


In delivering care, doctors encounter a diverse range of patients requiring different communication approaches – from the very young to the elderly. Various patient subgroups may present particular difficulties in terms of communication. For
example, doctors may find it more difficult to communicate with patients with a chronic or complex disease, a terminal illness or those for whom there is no diagnosis. Under these circumstances more effort must be made to communicate with the patient sensitively. In some cases an explanation of the patient’s illness will need to be paced over several sessions in order to suit the patient or family’s emotional or cognitive ability to attend to, comprehend or incorporate the information.

Patients themselves may have communication difficulties such as those with sensory impairments or speech problems, those with language barriers or learning difficulties, and patients from different ethnic groups. Communication with patients’ relatives and carers is also commonly required. To provide appropriate care, doctors must possess the appropriate skills to communicate sensitively with people, irrespective of cultural, social, religious or regional differences. In the UK, cultural, social and religious diversity is found in the population including the medical profession. In patient-doctor interaction the main responsibility for cultural sensitivity and understanding rests with the doctor. It is, therefore, imperative that medical education includes intercultural communication training.

In all doctor-patient interactions a variety of communication skills will be required for different phases of the consultation. During the start of a consultation, doctors must establish a rapport and identify the reasons for the consultation. They must go on to gather information, structure the consultation, build on the relationship and provide appropriate information.

A number of healthcare trends are increasing the need for strong communication skills in medicine. In relation to communication with patients, an increasing focus on shared decision making and communication of risk are two of the most important factors. For example, communication skills can help healthcare staff to
explain the results of epidemiological studies or clinical trials to individual patients in ways that can help patients to understand risk. Doctors can do this more effectively if they develop relationships with their patients and if they take into account knowledge and perceptions of health risks in the general public.

As noted above, the main responsibility for effective communication during consultations rests with the doctor. However, changes in the NHS are encouraging patients to be more proactive in their care. It is possible that, as a means of optimising patient care, health education in schools and other patient education initiatives could aim to improve patients’ knowledge of effective patient-doctor communication.

NHS Scotland’s Centre for Change and Innovation has highlighted several factors increasing the need for strong communication skills in medicine. These include:

- improving the patient’s ‘journey’, which requires advanced leadership, team working and communication skills
- cultural and organisational change
- the growing need for long-term management of chronic disease – this is believed to require a shift in doctor-patient interaction and healthcare team working to a partnership model
- the appraisal process which demands a sophisticated level of communication skills
- complaint handling and increasing litigation.
The benefits of good communication skills

Benefits of good communication can be identified for both doctors and patients.

Benefits for patients

- The doctor-patient relationship is improved. The doctor is better able to seek the relevant information and recognise the problems of the patient by way of interaction and attentive listening. As a result, the patient’s problems may be identified more accurately.8
- Good communication helps the patient to recall information and comply with treatment instructions thereby improving patient satisfaction.9,10
- Good communication may improve patient health and outcomes. Better communication and dialogue by means of reiteration and repetition between doctor and patient has a beneficial effect in terms of promoting better emotional health, resolution of symptoms and pain control.11
- The overall quality of care may be improved by ensuring that patients’ views and wishes are taken into account as a mutual process in decision making.
- Good communication is likely to reduce the incidence of clinical error.8

Benefits for doctors

- Effective communication skills may relieve doctors of some of the pressures of dealing with the difficult situations encountered in this emotionally demanding profession. Problematic communication with patients is thought to contribute to emotional burn-out and low personal accomplishment in doctors as well as high psychological morbidity.12 Being able to communicate competently may also enhance job satisfaction.
- Patients are less likely to complain if doctors communicate well. There is, therefore, a reduced likelihood of doctors being sued.8
Communication within the healthcare team

Good communication within the healthcare team is essential in order to ensure continuity of care and effective treatment for patients. Moreover, poor communication between professional staff has been identified as an underlying factor for failed communication with patients. For example, a patient may be given different information regarding their condition by different members of the healthcare team.

Although most healthcare professionals have a firm understanding of their own role, they may not necessarily understand others’ work or how their role fits in with the rest of the healthcare team. Good communication can deepen professionals’ understanding of different working cultures and professional language.

Communication with managers and other professionals, such as social workers, is equally relevant. Communication difficulties between doctors and with their managers is a leading cause of disciplinary problems. In 2003, a survey of BMA regional offices showed that ‘poor communication’ was identified as a significant factor in over a quarter of disciplinary action cases taken by employers against BMA members.*

Being a doctor incorporates the responsibility to teach others. Good communication skills are therefore essential in order to ensure the effective transmission of knowledge and to facilitate mentoring and guidance of medical students and doctors in training. The communication skills needed to publish research, educate, lead or inspire will extend to written and presentation skills in addition to the one-to-one oral communication required in patient consultations.

* This survey covered cases of personal misconduct where a penalty had been imposed, and that had been handled by BMA industrial relations officers between June 2001 and May 2003.
The profession’s need for communication skills training

Inquiries into serious medical incidents, for example the Bristol Royal Infirmary (BRI) Inquiry, government initiatives such as the lifelong learning framework, and complaint bodies such as the Health Service Ombudsman, have all stated the need for improved communication skills for healthcare professionals. For example, the BRI report recommended that education and training in communication skills be accorded a greater priority throughout a professional's career, from undergraduate education to continuing professional development.

The Health Service Ombudsman has identified a lack of communication between healthcare professionals, between professionals and their colleagues, and between professionals and carers which frequently lies at the heart of patient complaints. Common problems include poor handling of complaints, failure to obtain informed consent, poor nursing care and lack of liaison between services. Some of the key points raised in complaints investigated by the Health Service Ombudsman include:

- patients’ perception that they are given conflicting information by different healthcare professionals
- the need to make clear clinical notes that should be referred to at relevant times
- the need to involve patients in changes planned for their care.

Recent research shows that poor communication between healthcare staff and patients is still all too common. For example, when the Lothian Hospitals NHS Trust asked patients for their views on communication issues, they found that 60 per cent of patients complained about a lack of involvement in decisions about their care, 33 per cent said they had been given no explanation of test results and 31 per cent said they had no opportunity to talk to the doctor. Twenty-three per cent complained of nurses and doctors saying different things.
An increase in shift working, required by the introduction of the European Working Time Directive, will mean that higher numbers of individuals and teams are caring for patients over any given 24-hour period. Under these new hospital working patterns, improved communication between doctors will be essential to protect patient safety. The BMA junior doctors committee and the NHS National Patient Safety Agency has recently provided guidance to doctors, managers and other NHS staff on communicating information at the end of the shift. *Safe handover: safe patients*19 also makes training and systems-based recommendations to improve communication in this area.

The General Medical Council (GMC) stresses the need for communication skills in a number of its guidance notes.20,21,22,23 It encourages the acquisition of communication skills from the outset of undergraduate learning and produces guidance for general clinical training (the pre-registration house officer year),22 and general professional training (senior house officer training),23 both of which stipulate the need for sound communication skills. In its general guidance for doctors, good communication with patients and colleagues is seen as essential for effective care and trusting relationships.

The GMC recognises that the communication skills required throughout a doctor’s career are likely to change. Doctors should review their skills as part of their continuing professional development, and take part in educational activities as a means of maintaining and further developing their competence.21 The introduction of revalidation will offer opportunities for doctors to reflect on their competence in all areas, including communication skills. Doctors will be required to demonstrate that they are up to date and fit to practise medicine in line with the GMC guidance *Good medical practice.*21 This includes demonstrating professional working relationships with patients and colleagues.
Other medical professional bodies have highlighted the importance of communication skills and instituted various approaches for communication skills education:

**Examples of professional endorsement of the importance of communication skills for doctors**

- Publications from medical organisations, such as the BMA's board of medical education report on communication skills and continuing professional development (1998) and the Royal College of Physicians' publication *Improving communication between doctors and patients* (1997), have highlighted the importance of communication skills.

- The General Medical Council's Professional Linguistic and Assessment Board (PLAB) examination has separated its language and communication elements with the latter being assessed through role play.

- The Academy of Medical Royal Colleges, in its recommendations for general professional training, includes communication skills among the generic skills required of all trainees.

- Royal Colleges include communication skills assessment in their training. For example, the Royal College of General Practitioners has developed formal mechanisms using video recordings for assessing communication skills in candidates. The Royal College of Physicians has introduced communication skills assessment into its training.
The Royal College of Ophthalmologists includes communication skills in both the basic higher specialist training curricula and in the Part 3 MRCOphth examination.

- The London Deanery and NHS London have developed an online interactive educational programme in communication skills for healthcare professionals, including postgraduate doctors undertaking the foundation years of training: [www.healthcareskills.nhs.uk/](http://www.healthcareskills.nhs.uk/)

**The potential of communication skills education**

There is substantial evidence that communication skills can be taught, particularly using experiential methods.25

To be effective, communication skills teaching should include:9

- evidence of current deficiencies in communication, reasons for them, and the consequences for patients and doctors

- an evidence base for the skills needed to overcome these deficiencies

- a demonstration of the skills to be learnt

- an opportunity to practise the skills under controlled and safe conditions

- constructive feedback on performance and reflection on the reasons for any unconstructive behaviour.
There has been some criticism of studies assessing communication skills training for doctors. For example, it has been suggested that most do not include sufficient information about the training given to the study participants, making evaluation difficult. However, there is overwhelming proof that communication skills in the patient-doctor relationship can be taught and are learnt.
While the majority of doctors seek to encourage open and informative dialogue with patients, it is recognised that episodes of poor communication occur. However good a doctor’s communication skills, she or he will experience times when communication does not go according to plan. Identifying the specific factors inhibiting good communication depends partly on communication skills training, reflection and feedback.

Barriers to effective communication

While the majority of doctors seek to encourage open and informative dialogue with patients, it is recognised that episodes of poor communication occur. However good a doctor’s communication skills, she or he will experience times when communication does not go according to plan. Identifying the specific factors inhibiting good communication depends partly on communication skills training, reflection and feedback.

**Personal barriers to effective communication**

Current research highlights a number of barriers to communication ranging from personal traits to organisational constraints:

- a lack of skill and understanding of the structures of conversational interaction. For example, the importance of providing accessible information in a language that is tailored to the patient, giving structured explanations and listening to patients’ views, thereby encouraging two-way communication

- inadequate knowledge of, or training in, other communication skills including body language and speed of speech. Problems may be caused by insufficient personal insight into communication difficulties. In some cases communication will be hampered by factors as straightforward as poorly laid out furniture

- doctors undervaluing the importance of communicating. For example, not appreciating the importance of keeping patients adequately informed. In some cases this will stem from a wider imbalance in the relationship between doctor and patient

- negative attitudes of doctors towards communication. For example, giving it a low priority due to a concern primarily to treat illness rather than
focusing on the patient’s holistic needs such as psychological and social wellbeing. This is often an artificial distinction since health and ill health tend to be composed of physical, psychological and social components

- a lack of inclination to communicate with patients. This can be due to lack of time, uncomfortable topics, lack of confidence and concerns relating to confidentiality

- lack of knowledge about the illness/condition or treatment. This need not be a barrier to effective communication so long as doctors are honest about the limitations of their knowledge. Doctors should recognise that in many cases patients may be as knowledgeable or insightful about their own conditions as the doctor

- human failings, such as tiredness and stress

- inconsistency in providing information

- language barriers – doctors who qualify outside the European Economic Area (EEA) are required to take the International English Language Testing System (IELTS) test, administered by the British Council. However, those who qualify within the EEA do not need to take a language test. To gain employment in the UK doctors will need a level of English language proficiency but some doctors’ language ability will inevitably be better than others’

- personality differences between doctors and their patients. Research suggests that doctors may differ significantly from the UK adult population norms on some dimensions of personality including those which measure
an individual’s preferred mode of understanding. This suggests that there may sometimes be potential for miscommunication in the consultation process.\textsuperscript{30}

**Organisational barriers to effective communication**

Factors that contribute to and exacerbate poor communication are often related to the organisational constraints within which doctors work. Work constraints include lack of time, pressure of work, and interruptions.\textsuperscript{3,11} These are often symptoms of wider organisational problems that are beyond the doctor’s direct control. For example, when an emphasis is placed on ‘patient throughput’, time given to communicating with patients may not be given a high priority.\textsuperscript{3}

If communication between doctors and patients is to improve, it is vital that organisational barriers are tackled. Organisational support for communication is essential. While doctors need to ensure that they are able to communicate with people with widely different needs, organisations must support doctors, where necessary, by providing time, interpreting, advocacy and other services.\textsuperscript{8}
Communication skills in undergraduate education

The GMC’s *Tomorrow’s Doctors* (1993) signified a change in emphasis of undergraduate medical education, towards a learning process including the development of skills to interact with patients and colleagues. In the years following the publication of this guidance many medical schools invested heavily in the teaching and assessment of communication skills. Since 2002, the ability to communicate competently with patients has been a pre-condition of qualification for all healthcare professionals if they are to deliver patient care in the NHS.

Undergraduate communication skills education in England
Guiding principles for the commissioning, monitoring and provision of communication skills education for healthcare professions in England were developed in November 2003, following discussion between the Department of Health (England), Universities UK, the GMC, the Health Professions Council and the Nursing and Midwifery Council. One of the key guiding principles regarding medical education is that commissioners of education should ensure that the standards set out for communication skills in the GMC’s revised *Tomorrow’s Doctors* (2002) and the Quality Assurance Agency’s (QAA) subject benchmark statement for medicine (2001) are embedded within education provision and have been interpreted and delivered in the most effective way for meeting the students’, employers’ and ultimately the patients’ needs.
GMC standards for communication skills

- graduates must be able to communicate clearly, sensitively and effectively with patients and their relatives, and colleagues from a variety of health and social care professions. Clear communication will help them carry out their various roles, including clinician, team member, team leader and teacher.

- graduates must know that some individuals use different methods of communication, for example, Deafblind Manual and British Sign Language.

- graduates must be able to do the following:
  a. communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds, or their disabilities.
  b. communicate with individuals who cannot speak English, including working with interpreters.

- students must have opportunities to practise communicating in different ways, including spoken, written and electronic methods. There should also be guidance about how to cope in difficult circumstances. Some examples are listed below:
  a. breaking bad news
  b. dealing with difficult and violent patients
  c. communicating with people with mental illness, including cases where patients have special difficulties in sharing how they feel and think with doctors
  d. communicating with and treating patients with severe mental or physical disabilities
  e. helping vulnerable patients.

QAA’s benchmark statement for medicine (2001) states:

In relation to interpersonal skills, the graduate will be competent in the following areas of communication:

a. listening to patients, relatives/carers/partners and other healthcare professionals

b. explaining and providing patients and others with adequate information

c. mediating and negotiating with patients, carers and colleagues

d. handling complaints appropriately

e. liaising with other members of the healthcare team.

The guiding principles of communication skills training in England state that qualified staff must be able to demonstrate proficiency in communication skills if their post requires them to facilitate, interact with and support healthcare students. Other principles include the following:

- all stakeholders should ensure that students and staff fully understand the relevance of developing good communication skills for care management, the ability to practise effectively as a professional and the need to maintain professional registration
• communication skills go beyond the ability to talk to people. Stakeholders should ensure that students and the staff supporting them understand the breadth of skills required to practise. Stakeholders should work together to ensure that students recognise that developing communication skills is a continuing process throughout their professional careers, especially when moving into specialist areas.

• commissioners and providers of education must ensure that the assessment of communication skills is a common thread running through all learning, both in academic and clinical settings and not just those headed ‘communication skills’. [This is hoped to help convey the message that communication skills are an integral part of medical practice.] The methodology must be reliable and valid and the assessment given an appropriate weighting to reinforce the value of communication skills.

• the NHSU is expected to contribute to the sharing of learning materials for students and staff, and innovative proposals for meeting the standards and assessment of students’ performance.32
Good communication skills expected of healthcare graduates include the ability to:

- talk to patients, carers and colleagues effectively and clearly, conveying and receiving the intended message
- enable patients and their carers to communicate effectively
- listen effectively especially when time is pressured ie skills in engaging and disengaging
- identify potential communication difficulties and work through solutions
- understand the differing methods of communication used by individuals
- understand that there are differences in communication signals between cultures
- cope in specific difficult circumstances
- understand how to use and receive non verbal messages given by body language
- utilise spoken, written and electronic methods of communication
- know when the information received needs to be passed on to another person/professional for action
- know and interpret the information needed to be recorded on patients records, writing discharge letters, copying letters to patients and gaining informed consent
- recognise the need for further development to acquire specialist skills.

Undergraduate communication skills education in Scotland
Since 2000, the five Scottish medical schools have had a consensus set of ‘Curriculum Outcomes’ designed to assist curriculum planners, teachers and medical students. Communication skills are included in these; as a key outcome they are assessed separately.

The Scottish Doctor Learning Outcomes for the Medical Undergraduate in Scotland

Communication
Good communication underpins all aspects of the practice of medicine. All new graduates must be able to demonstrate effective communication skills in all areas and in all media eg orally, in writing, electronically, by telephone etc. This could include:

General principles of good communication
• being able to listen and use other appropriate communication techniques including an appreciation of non-verbal communication/body language (one’s own and the interviewee’s)
• gathering and giving information with good record keeping and correspondence skills
• mediating, negotiating and dealing with complaints
• making oral presentations and writing reports/papers
• telephone usage

Communicating with patients / relatives
• answering questions and giving explanations and/or instructions
• strategies for dealing with the ‘difficult’ consultation including
defusing aggression, breaking bad news and admitting lack of knowledge or mistakes
• making requests eg post-mortem, organ donation
• obtaining informed consent
• confidentiality

Communicating with colleagues
• transfer of information orally, in writing and electronically
• the ‘art’ of the good discharge summary and patient referrals
• communicating with police and procurator fiscal/coroner
• proper procedure when such communication is necessary and how to relay appropriate information without breaking rules of confidentiality
• communicating with media and press
• a clear understanding of who should give information to the media and press and what form it should take including the need to maintain confidentiality where individual patients are concerned

Communicating as a teacher
• recognising the importance of sticking to what you know, knowing your own limitations and admitting when you don’t know
• some basic teaching techniques eg demonstrating practical procedures, using various teaching aids, etc

Communicating as a patient advocate
• how to recognise when this is appropriate and how it may be accomplished effectively

Communication skills education in medical schools

The communication skills training now provided by medical schools includes explaining and negotiating skills, instruction in breaking bad news, consulting patients and relatives, dealing with angry, difficult and reluctant patients, demonstrating empathy and giving and receiving information. Communication skills education may be delivered as a discrete teaching unit although, in several medical schools, communication skills are fully integrated longitudinally into the students’ medical curriculum. This has the advantage of conveying a clear message that communication skills are integral to medical practice.

As communication skills are essential for all healthcare professions, communication skills training has been one of the first areas to be included in interprofessional teaching. King’s College London, for example, has an Inter Professional Education programme for year 1 health students which focuses on core communication skills and ethics. The University of Bristol Medical School runs a joint course for medical students and nursing students from the University of the West of England dealing with care of the elderly. Similarly the University of Southampton and University of Portsmouth integrate communication into their Common Learning Programme.

During undergraduate medical education, experiential learning is important for the development of communication skills. Most universities use small groups, videos and interactive sessions to teach communication skills. Some also use professional actors to take on the role of a patient in role play situations. As an example, the third year of the medical degree at Bart’s and the London School of Medicine and Dentistry includes a clinical communication assignment which entails students audio taping a patient interview (with consent), analysing the communication process and undertaking self assessment of their skills, effective behaviours and areas for improvement. The task is designed to allow assessment of students’ insight, attitudes and skills and it is followed up with remedial work for students who fail the assessment.
Assessment may take the form of logbooks and Objective Structured Clinical Examinations (OSCEs). Guy’s, King’s and St Thomas’ School of Medicine have OSCEs covering cross cultural communication and inter and intraprofessional communication. The University of Dundee prevents students without adequate basic skills, including those who fail to demonstrate communication skills, from progressing to clinical training.32

It has been noted that there is a general lack of long term follow-up studies of the development of communication skills after training.27 Communication skills, however, seem to be easily eroded if they are not maintained by practice.27

**Attitudes of staff and students**

The BMA’s *Communication skills education for doctors: a discussion paper* (2003) outlined a number of barriers to delivering good communication skills training in undergraduate communication, including negative attitudes towards communication skills training in some staff and students. With concrete changes to the undergraduate medical curriculum since 1993, and especially since 2002, many of these attitudes have probably changed. However, the 2003 ‘guiding principles of communication’ document produced by the Department of Health and other bodies perceived a continuing barrier to communication skills training in pockets of staff, who take a very narrow view of communication skills and cannot see their wider relevance or the need for behaviour change. The solution to this barrier proposed in the guiding principles was to ensure that students encounter role models in clinical and academic settings who can demonstrate a proficiency in a range of communication skills.32
Some research suggests that attitudes towards communication skills learning in undergraduate education vary by demographic and education-related characteristics. A study of almost 500 medical students in the Universities of Nottingham and Leicester found that students with more positive attitudes towards communication skills learning tended to be female, tended to think that their communication skills needed improving and tended not to have parents who were doctors.\textsuperscript{33}

It seems likely that the earlier communication skills are introduced to medical students the more likely they are to perceive them as an integral element of medical practice. A small number of medical schools, for example Bart’s and The London School of Medicine and Dentistry, explicitly assess communication skills as part of their admissions criteria.
Communication skills education for doctors: an update

Communication skills will be included in the competencies needed to complete the new Foundation Programme which, from August 2005, will apply to all those graduating from medical school. This assessment of communication skills will go beyond that in medical schools and a higher level of communication skills will be expected in the second year (F2) than in the first (F1).

Several medical specialties require communication skills for certification. For example, since 1996 all doctors receiving their Certificate of Prescribed Experience from the Joint Committee on Training for General Practice (JCPTGP) have been required to demonstrate competence in consulting and communication skills.

A large proportion of senior doctors have still received no training in communication skills. For this reason, and because many doctors will require additional communication skills training during their career, efforts are being made to ensure that doctors can access good communication skills support as part of their continuing professional development.

Communication skills are now regarded as a core competence. Assessment of communication skills will be necessary as part of the doctors appraisal and personal development plans. In addition, revalidation will also take communication skills into account. For example, the RCGP will require physicians to demonstrate evidence of at least one half-day of learning in communication skills in the five years preceding revalidation. Examples of such learning may include attendance at a communication skills course, shared surgeries with another doctor, or peer review or self-analysis of audio or video-taped consultation.

Communication skills may be identified as an area for postgraduate development by an individual doctor. Alternatively, areas of skill development may be identified by a doctor’s colleagues. Either could happen as part of the appraisal process.
However, it is also essential that doctors continually monitor and support each other’s communication skills and take seriously any communication problems which they see among their colleagues. The GMC’s *Good medical practice* states that doctors ‘must protect patients from risk of harm posed by another doctor’s or other healthcare professional’s conduct, performance or health’.21

**Examples of postgraduate communication skills education initiatives**

NHS Scotland is developing a communication skills programme, initially to be provided for consultants. This is likely to comprise a range of components and approaches including diagnostic instruments to help consultants reflect on their own practice and acquire feedback from patients and peers, experiential training courses, peer support and e-learning.8

The Communication Skills Unit (CSU), based in the Department of General Practice, University of Wales College of Medicine, works with undergraduates, newly qualified and experienced health professionals. It focuses on providing evidence-based training programmes for primary and secondary care groups and teams. This is done partly through a number of innovative approaches to training such as the ‘context bound training method’. This method enables training to be integrated into clinicians’ daily work thus enhancing the reality of training and reducing the need for clinicians to spend time in ‘classrooms’.35 The CSU has also developed an individual support programme to improve the skills of health professionals for whom effective communication is closely bound up with clinical, organisational and performance issues.36 Healthcare practitioners or students in Wales may be referred or refer themselves to the unit for support connected with stress, distress or confusion about communicating with patients or colleagues. More information about the CSU can be found on its website [www.uwcm.ac.uk/csu](http://www.uwcm.ac.uk/csu)
The NHSU will include communication skills in the training it offers to NHS staff. From spring 2005 for example it will roll out a programme on advanced communications skills for senior cancer care professionals.
Recommendations

Good communication skills are promoted by the profession by means of formal accreditation and through educational opportunities. While improvements have been recognised, particularly with regard to communication skills training at undergraduate level, in order to ensure a sustained commitment to communication skills training development, a number of key factors need to be addressed.

1. The non-clinical elements of medicine are often as important as the clinical aspects. Positive attitudes toward non-clinical aspects of medical education, including communication skills, should be encouraged and efforts should be made to raise the profile of communication skills training amongst the profession.

2. Healthcare professionals must actively strive to achieve good communication skills by evaluating their own abilities.

3. Education providers need to ensure that appropriate and effective training opportunities are available to doctors to develop and refine communication skills. In particular:

   • Medical schools must be encouraged to provide the best possible communication skills training as part of the core undergraduate curriculum. This training should have set objectives and clear methods of assessment.

   • More communication skills training programmes should be developed at postgraduate level. Doctors could use the appraisal process as a vehicle for discussing the success of communication skills training.
4. Organisational support for communication is essential. Organisations must support doctors, where necessary, by providing time, interpreting, advocacy and other services.

5. It is imperative that medical education includes intercultural communication training. Doctors should be given opportunities to develop their skills to communicate sensitively with people, irrespective of cultural, social, religious or regional differences.

6. Communication skills training should not focus narrowly on oral communication between doctors and patients. It should address all aspects of communication skills, including written and interprofessional communication.
Appendix I – Four examples of communication skills training at medical school

The following four examples of communication skills training at undergraduate level were sent for inclusion in this paper by the medical schools involved. The board of medical education is always keen to hear of communication skills courses offered at both undergraduate and postgraduate level. The examples below demonstrate the diversity of approaches taken by medical schools to communication skills education.

University of Bristol

Communication skills are taught as a vertical theme throughout the five years of the medical undergraduate curriculum. The theme is led from the Division of Primary Health Care. Using a variety of different methods, teaching needs in communication skills are translated into practice appropriate to the stage of the curriculum and explicitly taught in several places. These include:

- one session in the first term of year 1 (an introductory lecture and one afternoon session on the doctor-patient relationship) as part of the Society, Health and Medicine course
- a lecture and three three-hour role play sessions with actors as patients during year 2
- one three-hour simulated patient session in year 3
- three three-hour sessions during the Care of the Elderly and Primary Care attachments in year 4; in Palliative Care in year 5; and on the PRHO shadowing course focusing specifically on communicating at the primary/secondary care interface
- professional behaviour and attitudes, which include communication skills, are formatively assessed at the end of each clinical attachment.
Communication skills are assessed at regular intervals during years 2 to 5. In Year 5, the final year, there is a summative assessment in the Final Objective Structured Clinical Examination (FOSCE). Several stations include a communication skills element. The medical school is aiming to provide more teaching of communication skills in an interprofessional setting. Currently there is joint work with nursing students from the University of the West of England in the Care of the Elderly course. The next challenge is to increase the proportion of time that is spent looking at the communication skills required for communication with people other than patients, e.g., relatives, carers and colleagues from other disciplines, as well as professional organisations and the media. This will require an involvement from clinical colleagues other than those who work in primary care.

**University of Cambridge School of Clinical Medicine**
The University of Cambridge School of Clinical Medicine has developed a ‘Comprehensive Clinical Method’ (CCM) vertical strand extending throughout the clinical course. Its overall aim is to provide a thorough grounding in the skills of medical interviewing, explicitly integrating communication skills teaching with ‘traditional’ clinical methods.

The CCM strand sessions make up approximately three weeks of the total clinical course. In the introductory course, the CCM strand utilises a mixture of lectures, demonstrations, small group work and experiential interactions with both real and simulated patients. Several sessions are experiential with simulated patients and video-recording covering in turn:

- initiating the session
- gathering information
- building the relationship
The CCM strand is integrated with clinical attachments so that medical interviewing and communication skills instruction are an overt component of each attachment’s teaching. The vertical strand has been carefully planned so that communication issues relevant to each attachment are considered alongside the clinical challenges of that particular specialty. In each clinical attachment there is at least one half-day session jointly taught by the CCM strand facilitators and specialists.

The following sessions have been established or are being planned for the future (planned sessions in italics)

**Phase 1:**
**General practice:**
- Cultural and social diversity (1)
- Breaking bad news (1)
- Observed medical interviews in general practice

**Medicine for the elderly**
- Communicating with elderly and sensory-impaired patients

**Medicine and surgery**
- Clinical reasoning in the medial interview
- Feedback on a whole videoed interview (two sessions)

**Phase 2:**
**Obstetrics and gynaecology**
- Cultural and social diversity (2)
Genito-urinary medicine
   The sexual history

Psychiatry
   Assessing suicidal risk and depression following an overdose
   Interviewing and assessing the patient with delusions and hallucinations

Neurosciences
   The explanation and planning course (three sessions)

Paediatrics
   Interviewing children and parents

Phase 3:
   Medicine and surgery
   Evidence-based patient choice
   Informed consent: explanation of risk and framing

Accident and emergency, oncology, general practice, peri-operative medicine
   Death and dying including:
   Breaking bad news (2)
   Palliative care
   Sudden death issues
   Organ donation
Phase 3 and the pre-registration year:

Communicating with other professionals

- Colleagues in medicine
- Colleagues in nursing and professions allied to medicine
- Interpreters
- Administrators and managers
- Team skills
- Negotiation skills

Presentation skills

- Medical records (written and computerised)
- Letter writing
- Oral presentation skills
- Making presentations and lectures
- Applying for jobs

Method of teaching and learning

The mainstay of CCM teaching is the use of simulated patients to enable students to practise and rehearse interviewing skills in safety. It also relies heavily on video recording so that students can watch themselves in practice and gain insight into their own skills – VHS tapes are provided to each student to record interactions with simulated patients throughout the course. Students take responsibility for helping colleagues by providing well intentioned feedback on their performance and by contributing to group discussion so that everyone benefits.

Formative Assessment

Ongoing feedback to learners is an integral part of the experiential teaching methods employed in communication work and constitutes the primary formative assessment process. Written into the structure of the strand are many
opportunities for well-intentioned, structured and descriptive feedback to students. At the end of some clinical attachments there are also formative OSCE assessments of history taking and communication skills.

**Summative Assessment**
The Clinical School has developed integrated OSCEs at the end of phase 1 and 3 of the clinical course, as part of students’ summative assessment: these jointly assess history taking and communication skills, physical examination and practical clinical skills. The new finals examination to be introduced in June 2005 will include a 12 station Simulated Clinical Encounter Examination that will assess all aspects of students’ communication skills.

*Imperial College of Science, Technology and Medicine*
Formal teaching in communication skills is undertaken in the first and second years of the course. The material is covered during interactive sessions or problem based learning, and each session includes assessments with written feedback from students. Each teaching session is scheduled for three hours and the total time devoted to this activity over the two years is 30 hours.

**Year 1**
Session 1: Consultation demonstrations  
Session 2: Non-verbal communication and presentation skills  
Session 3: Patient-centred communication  
Session 4: Videotape – talking with patients  
Session 5: Interviewing simulated patients.

**Year 2**
Session 1: Taking a medical history  
Session 2: Written communication
Session 3: Presenting patients
Session 4: Interviewing simulated patients
Session 4: Cross cultural communication and working with interpreters

Oxbridge entry students.
Those students arriving from Oxford or Cambridge, receive a clinical integration course before starting on the wards. This comprises:
   - Session 1: Patient-centred communication
   - Session 2: Non-verbal communication and presentation skills
   - Session 3: Taking a medical history and written communication.

Years 3 and onwards – examinations
The teaching of communication skills represents an important part of the clinical elements of the course. At the end of the third year the students are required to sit a written paper and are also examined on their clinical skills. Communication skills are included in an OSCE assessment. The final examinations are in the PACES format, and communication skills form part of that assessment.

University of Nottingham
Communication skills teaching, has been embedded in the curriculum for around 10 years.

Training good communicators
Years 1-2: Introduction to talking and listening, basic history taking, non-verbal communication, people with communication problems (children, elderly, foreign language, people with a hearing impairment).

Years 3-4: Analysing history taking, communications between professionals, extensive contact with patients in hospital and the community.
Year 5: Advanced communication skills, dealing with anger, collusion, denial and breaking bad news.

Plans are being developed to extend communications teaching into year 6, the PRHO year.

**Involvement of general practice**

Years 1-2: Seminars on basic communication skills, student observation of consultations, role play history taking, supervision of presentations within seminar groups, examiners OSCEs.

Year 3: Community follow up, seminars on communications between healthcare professionals, discussing patient’s understanding of their illness and oral presentations.

Year 4: GP attachment, supervised consultations, videotaped consultations, videotaped consultations with actors – group and supervisor feedback, breaking bad news and oral presentations in small group teaching sessions.

Year 5: Seminars dealing with anger, collusion, denial and breaking bad news examined in ‘final’ OSCE.
Appendix II – List of respondents to the 2003 communication skills paper

The following individuals and organisations responded to the 2003 paper Communication skills education for doctors: a discussion paper.

1. BMA General Practitioners Committee
2. Professor H Dua, Vice President, Royal College of Ophthalmologists
3. RCOG Consumer’s Forum, Royal College of Obstetricians and Gynaecologists
4. Professor T S Murray, NHS Education for Scotland
5. Dr Ruscoe, Acting Postgraduate Medical Dean, South Western Deanery
6. Ms M Guinness, Head of Communications, Cumbria and Lancashire Strategic Health Authority
7. Sir Liam Donaldson, Chief Medical Officer, England
8. Professor D Nutt, Dean of Clinical Medicine and Dentistry, University of Bristol Medical School
9. Dr R Philipp, Consultant Occupational and Public Health Physician, Bristol Royal Infirmary
10. Ms W Garlick, Principal Policy Adviser, Consumers Association
11. Dr P Kinnersley and Professor S Rollnick, Directors, Communication Skills Unit, University of Wales College of Medicine
12. Dr B McMullen
13. Ms E Lightfoot, Director of Professional Standards, Royal College of Anaesthetists
14. Dr Hall, Chief Medical Officer, Wales
15. Dr S McAfee, Consultant Clinical Psychologist, North Dorset PCT
16. Dr D Rutter
17. Dr G Holsgrove, Head of Postgraduate Educational Services, Royal College of Psychiatrists
18. Dr E M Armstrong, Chief Medical Officer, Scotland
19. Dr G Taylor, Director of Postgraduate General Practice Education – The Department for NHS Postgraduate Medical and Dental Education (Yorkshire)

20. Dr J Richardson, Lecturer in medical education, Royal Free and University College Medical School

21. Dr S Kelly, Director of Postgraduate General Practice Education, West Midlands Deanery

22. Professor Sir Graeme Catto, Dean, Guy’s, King’s College and St Thomas’ Hospitals’ Medical and Dental School

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