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Communication skills teaching comes of age

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The doctor–patient relationship (a good bedside manner) has always been recognised as central to medicine. However, the systematic teaching of communication skills and assessment of students communicating with their patients is a relatively new element in medical education. It is only recently that we have moved from the belief that entrants to medical school, by virtue of their intelligence, are innately effective and sensitive communicators, and that any who aren't can pick up the skills by osmosis and good intentions. Now, communication skills teaching to undergraduates has come of age. Building on pioneering work introducing the use of simulated patients (e.g. Barrows in North America¹ and Whitehouse and colleagues in the UK²), communication skills education has now developed to the point where, for example, medical students in the UK are expected to learn core skills in all components of the medical interview, such as information gathering, and explanation and planning, as well as those

required in challenging communication situations such as the breaking of bad news, and to be assessed in their performance of these tasks before they can qualify.³ However, there is evidence of considerable variability in course content, timing, duration and methods of assessment, which means that students at different schools may have very different experiences.⁴

Schools may still need guidance on how much communication skills teaching should be delivered and which aspects should be covered

At the same time, many subjects compete for space in already overcrowded medical curricula. Although space in teaching and assessment schedules has been carved out and dedicated posts created, schools may still need guidance on how much communication skills teaching should be delivered and which particular aspects should be covered. To help inform these debates and to promote excellence, the UK Council for Communication Skills Teaching in Undergraduate Medical Education has produced a consensus statement on the key content of communication curricula, which is published in this issue.⁵

The consensus statement is based firmly on a patient-centred clinical approach,⁶ for which there is now considerable supportive evidence,⁷

and it is significant that 'respect for others' is the central domain. The tasks of the consultation derive from a number of models, notably the Calgary–Cambridge approach, which is widely used in UK medical schools and is gaining increasing application worldwide.⁸ The consensus statement demonstrates that competent clinical communication comprises far more than taking a polite medical history, is a core requirement for the effective and safe practice of medicine, and covers a wide range of clinical tasks and skills. Grounded in professionalism, ethical and legal principles, evidence-based and reflective practice, the domains, tasks and skills form a helical curriculum.

The purpose of the statement is not to define the precise method of delivery, but to guide overall content

Curriculum planners and communication teaching leads may see the consensus statement as setting out an agenda that can never be squeezed into an already overcrowded curriculum and which will add greatly to their teaching burden. Although modest increases in curricular time *may* be needed, the statement provides the rationale and demonstrates, through its 'dial-a-curriculum' approach, how, by carefully choosing the content of scenarios, teaching can address several domains simultaneously. For example, by teaching about how to

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explain a diagnosis to an elderly person by telephone, the facilitator can cover issues pertinent to all three aspects of this task and the learner can address his or her own particular learning needs. The purpose of the statement is not to define the precise method of delivery, but to guide overall content; it is not intended to limit or constrain teaching methods. However, progress towards comprehensive coverage of this teaching in medical schools should be significantly aided by the statement.

Although crafted with UK medical schools in mind, the model may be transferable to curricula for other health professionals. Just as importantly, it should provide a template for developing communication competence further in the post-graduate years. It is something of a paradox that communication skills training is not a core component of postgraduate training or continuing professional development curricula (with notable exceptions, such as general practice vocational training⁹), yet communication failures contribute significantly to patient (dis)satisfaction, medical error and litigation.^{8,10}

All medical schools have the shared purpose of producing high-quality graduates and the statement demonstrates the significant benefits of collaboration

The statement is the most significant output to date of the UK Council of Communication Skills Teaching in Undergraduate Medical Education. Formed in 2005, the Council is comprised of representatives of each of the 33 UK medical schools and meets at 6-month intervals to advance the teaching of communication. All medical schools have the shared purpose of trying to produce high-quality graduates in line with the decrees

of their national regulatory board, and the statement demonstrates the significant benefits of collaboration. Ideas can be shared and disseminated, enthusiasm for teaching (re)kindled, assessment processes compared, scholarship and collaborative research encouraged, national awareness increased and the overall quality of education improved.

The most important factor in successful collaborative working is a shared commitment to improving the teaching of medical students

In the UK, medical schools are reasonably close, so that face-to-face meetings can be easily arranged; in other settings, such as in North America, distance may be a constraint. However, modern communication technology facilitates interaction and a key feature of the UK Council's activities has been the establishing of an active, password-protected website and blog to promote electronic communication. From its inauguration, the Council has encouraged more than just meeting and talking and has developed the online sharing of resources such as teaching plans, simulated patient scenarios and assessment protocols, including a comprehensive, searchable database of patient scenarios for both teaching and assessment purposes. The Council has also encouraged members to visit one another's departments to compare teaching methods. Conferences play an important role in networking and the sharing of ideas, but are unlikely to have the specific focus that collaborative groups such as the UK Council can. The most important factor in successful collaborative working is a shared commitment to improving the teaching of medical students, something to which every medical educator should be able to sign up.

CONFLICTS OF INTEREST

Both authors are members of the UK Council and contributed to the development of the consensus statement.

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