

which the intervention took place would be warranted. Insights into what went wrong would help us develop better means of providing timely, reliable, learner-centred feedback on an ongoing basis.

Reflection demands skill, involves the brain and the mind, requires attention to high-quality feedback and is subject to scientific investigation and understanding

Reflection is part of the art of medicine. However, like the visual and performing arts, reflection demands the development of specific skills, involves the brain and the mind, requires attention to high-quality feedback and is subject to scientific

investigation and understanding. The three studies in this issue of *Medical Education* help to illuminate the processes that underlie reflection. The goals of reflection – insight, wisdom and informed flexibility – though, like beauty, harmony and health, are much harder to define and measure.

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Improving communication with all patients

Gregory Makoul

The UK Consensus Statement on the content of communication skills curricula in undergraduate medical education well represents the breadth and depth of communication in medicine.¹ The notion of rotating concentric rings within the 'communication curriculum wheel' may prove useful to those who plan undergraduate as well as graduate and continuing medical education programmes. Conceptually, these rings expand outward from a core of Respect for Others to Theory and

Evidence, Tasks of Clinical Communication, Specific Issues, Media, and Communicating beyond the Patient, all embedded within a set of overarching contextual themes that include Professionalism, Ethical and Legal Principles, Evidence-based Practice, and Reflective Practice. More immediately, the wheel and its rings begin to convey the sheer number of vectors and challenges for effective communication in, and about, medicine.

Reading the Consensus Statement prompted me to reflect on approaches to teaching and assessing two critically important and currently hot topics: cultural competence and health literacy. A quick MEDLINE search reinforces the impression that both topics have received considerable attention in the last decade. The overall trajec-

tory of publications has been truly impressive, ranging from a handful of articles in the early 1990s to more than 280 on cultural competence and over 160 on health literacy in 2007 alone.

Early educational approaches toward cultural competence were characterised by a focus on the language and culture of particular groups

As noted by Betancourt, early educational approaches toward cultural competence were characterised by a focus on the language and culture of particular groups, which 'can lead to stereotyping and oversimplification of culture'.² Contemporary approaches focus on learning about, and addressing, the frame of reference of individual patients (i.e.

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patient-centred care). Although these certainly represent an advance, the current conception of cultural competence tends to be discussed within the context of cross-cultural encounters. The danger is that trainees may be getting the message that essential aspects of patient-centred care are only important if patients look or sound different from them. In reality, it is very clear that patients and doctors have cultures of their own. Each day of medical education widens the gap between the perspective of trainees and that of patients.

Contemporary approaches focus on learning about and addressing the frame-of-reference of individual patients

In his book *Patients and Healers in the Context of Culture*, psychiatrist and medical anthropologist Arthur Kleinman offered a set of questions designed to elicit patients' explanatory models of illness:³

- 1 What do you call your problem?
- 2 What do you think has caused your problem?
- 3 Why do you think it started when it did?
- 4 What does your sickness do to you? (How does it work?)
- 5 How severe is it (will it have a short or long course?)
- 6 What do you fear most about your sickness?
- 7 What are the chief problems your sickness has caused for you?
- 8 What kind of treatment do you think you should receive? (What results do you hope for?)

Questions of this sort are relevant to patient-centred care for all patients. As trainees may not be comfortable asking these questions in exactly these terms, medical educators could encourage them to develop their own approach. For

instance, one could ask 'How does this affect your life?' or 'Does it get in the way of doing things?' rather than 'What does your sickness do to you?' The logic of applying patient-centred principles in all encounters is certainly compelling; eliciting, respecting and addressing patient perspectives (e.g. conceptions, values, needs, preferences) is the essence of patient-centred practice. Moreover, it is entirely consistent with the stated goal of the cultural competence movement, which is to provide all patients with the highest quality of care 'regardless of their race, ethnicity, culture, class, gender, language proficiency, or any factor that makes them "distant" from us'.⁴

Research on health literacy has highlighted the importance of ensuring understanding

Health literacy has been defined as 'the degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions'.⁵ Appreciation for assessing and addressing literacy has increased dramatically, and research on health literacy has highlighted the importance of ensuring understanding. That said, the argument outlined in relation to cultural competence applies to addressing health literacy as well. Specifically, it seems more than reasonable that trainees should learn to use plain language and to check understanding with all patients, not only those who may have limited reading ability or difficulty in navigating the health care system. There is no doubt that health literacy is a critical issue for research and development, and that trainees should learn about the significant challenges encountered by people with poor literacy skills.

However, their efforts to ensure effective communication should extend beyond this segment of the patient population.

Doctors-in-training and doctors-in-practice should treat learning about the patient perspective and ensuring understanding as tasks of clinical care that apply across the board

In summary, initiatives geared toward improving communication with all patients – not just those from different cultural backgrounds or with low health literacy – are likely to be most successful. Adopting the parlance of the UK Consensus Statement, doctors-in-training and doctors-in-practice should treat learning about the patient perspective and ensuring understanding as tasks of clinical care that apply across the board, rather than as specific issues that apply only to some patients and some situations. This approach is consistent with the Consensus Statement itself, as well as with the notion that effective communication is based on respect for others as unique individuals.

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Communication skills teaching comes of age

Paul Kinnersley¹ & John Spencer²

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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