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How to Do It

Teaching communication skills to clinical students

I C McManus, C A Vincent, S Thom, J Kidd

Seven years' experience in teaching communication skills to first year clinical students at St Mary's Hospital School of Medicine is described. The first component consists of a day during the introductory clinical course; this is divided into a lecture and small seminar groups and involves behavioural scientists and clinicians from many departments. The second component uses simulated patients and video feedback and takes place in small groups later in the year. Participation of the students through active critical discussion, role play, and interactive video feedback are important aspects in the success of the course. The methods have been refined through evaluation by students and tutors. This article aims to allow others, already running or considering such a course, to develop effective courses within the practical constraints of their own institutions.

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Communication skills are now widely acknowledged as having a central role in clinical practice. The General Medical Council has stated that communication skills are fundamental to patient care and include history taking, involving patients in decision making, and giving treatment, advice, support, and counselling.[1] Most essential diagnostic information arises from the interview, and good communication increases patient's knowledge, satisfaction, and compliance and positively influences health.[2,3] Poor communication has been implicated in medical accidents[4] and in subsequent litigation.[5] Complaints about doctors by the public usually do not deal with clinical competence but with problems of communication.[6]

Teaching of communication seems to be both feasible and effective. Although some early research findings have been criticised,[7] other studies have clearly shown beneficial outcomes.[3,6,8-12] Without specific training, medical students' communication skills seem to decline during medical training.[10,11,13-15]

Teaching of communication skills has been slow to develop. In 1983 Wakeford found that one third of British medical schools offered no communication skills teaching, and training in the others typically amounted to only one or two hours of video recording and replay.[16] By the time of the 1992 GMC survey there was some improvement; only three out of 28 medical schools did not teach any communication skills, although it was usually taught as part of general practice or psychiatry, with only four schools including teaching within general medicine and surgery.[17] In 1991 Whitehouse reported that teaching of communication skills accounted for less than 2% of curriculum time.[18] Methods varied from formal lectures to analysis of student interviews. Video feedback was a part of only some courses, and students seldom had the opportunity to experience more than one or two sessions of feedback. Role play was commonly used in group work but the use of simulated patients was rare. Assessment was usually subjective and given only by the doctor or tutor. The GMC survey found that only seven schools included communication skills as a formal part of final examinations.[17] In 1992 the University of London stated that newly qualified doctors should be competent in communication skills and have received formal training in the subject.[19]

St Mary's Hospital Medical School has provided general communication skills training to first year

clinical medical students since 1986. Since the 1970s the department of general practice has also provided approximately 10 hours of teaching to second year clinical students, and other clinical departments such as oncology, obstetrics, and paediatrics have given teaching on specific aspects of communication. This paper describes the teaching we have developed for first year clinical students. This takes place during medical and surgical attachments and forms the basis of an integrated programme that runs throughout the clinical years. The methods described are not the only ways of teaching communication skills, but we have used them extensively and found them to be successful, and we believe they would provide a sound basis for any introductory course.

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Introductory course in communication

The course for first year clinical students contains two elements. The first, which is given to the whole year simultaneously, takes place during the introductory clinical course; its aim is to provide technical knowledge and increase awareness. The second component uses simulated patients in small groups with video feedback and takes place while students are attached to junior medicine and junior surgery firms; it aims to provide realistic practical experience with feedback. These two components, which have different aims (box 1), will be described separately.

Introductory day

The introduction to communication skills takes place during the first days of the clinical course, thereby emphasising the central role of communication in good medical practice. Students are helped to recognise that good communication is important to clinicians in all specialties by the participation of behavioural scientists and practising clinicians from many departments—anaesthetics, continuing care, clinical pharmacology, endocrinology, general surgery, medicine, nephrology, obstetrics and gynaecology, oncology, paediatrics, public health, and respiratory medicine. Although in the early years we emphasised why communication skills were important, students now seem to accept that communication is important and our emphasis has shifted to how to communicate. Box 2 summarises what we have learnt about running the introductory day.

Box 1—Aims of teaching

Introductory day

- To emphasise the central role of good communication in *all* branches of medicine
- To increase knowledge about doctor-patient communication
- To provide "conceptual tools" for analysing problems in communication, and to introduce appropriate technical terms

Small group teaching

We try to provide a safe environment in which students can discover things for themselves. The session is also presented as a safe forum for experimenting with communication, without the ethical problems of dealing with a real patient and without the humiliation that may follow blunders on the wards. In the sessions the students should aim to:

- Gather information necessary for an accurate diagnosis in a way that is efficient and orderly but also sensitive to the patient's needs and concerns
- Give information in a way that is clear and comprehensible; does not cause undue distress; allows the patient to express anxieties and ask questions; and ensures that the patient has understood correctly
- Achieve some understanding of the patient's emotional state and of the patient's understanding and beliefs about the illness
- Understand that different approaches are needed for different patients and different problems: a gentle, empathic approach might be needed for one patient, while another might prefer a brisk professional manner
- Understand that doctors also vary in their personalities and abilities: there is no one correct approach; each student must find his or her way of approaching particular problems

Box 2—Running an introductory day

Keep it varied, with different types of teaching

Lectures
- Should emphasise that communication *can* be taught
- Should provide technical terms and a structure
- Should be concise
- Should be given by good communicators
- Presentations involving actors have been very successful

Video material
- Use many *short* extracts
- Involve students actively by obtaining comment or providing systematic assessment
- Use diverse sources
- Encourage discussion by using teachers from different specialist backgrounds

Role play
- Provide starting scripts
- Let each student play the roles of doctor, patient, and observer
- The observer should comment at the end of each interview on the doctor and the patient
- Observers should comment on what went *well* before commenting on what could have been done differently
- Use different techniques such as
  - Rerunning difficult topics
  - Reversing doctor and patient for a difficult topic
  - Encouraging students to provide scenarios
  - Asking students to provide information as well as obtain it

TEACHING LARGE GROUPS

Teaching communication skills can be very labour intensive, but that load is reduced by dividing the day. The morning part is based in the lecture theatre and involves half or all of the class (about 110 students); in the afternoon the students are divided into small seminar groups, typically of 12 students, with a clinician and a behavioural scientist teaching each group.

We have tried several different formats for the morning. Interest is maintained by having several teachers, including patients, senior students, nurses, and the hospital chaplain. Formal lectures emphasise the role of good communication in history taking and provide conceptual tools, such as distinguishing verbal and non-verbal communication, specifying a formal model of interviewing,[20] introducing technical terms such as "calibration" (the assessment of a patient's intellectual level and the extent of specific medical knowledge), and discussing problems in facilitating or controlling an interview. Videotape provides clinical examples, and in recent years students have participated directly by observing and rating aspects of real, videotaped consultations with the Brown interview checklist.[21]

A recent, and particularly successful, innovation has been the use of actors to portray different styles of communication in the context of a general lecture and discussion. These actors have already, in the course of

teaching using simulated patients, been interviewed by many students, and they are familiar with common mistakes and the different styles students adopt. One actor plays a patient, the other a clinical student; they present a series of brief interviews showing an over-friendly approach, a nervous and hesitant student, a cool and distant clinical manner, and so on. Another series shows the different problems that arise in explaining common tests to patients, again based on our experience during teaching with simulated patients. Students find the vignettes memorable, enlightening, and amusing: they are evaluated as "very successful" by 92% of the students, and they also provide an excellent introduction to the later teaching with simulated patients.

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SMALL GROUP TECHNIQUES

Techniques in the small group seminars have evolved over the years, although discussion of video-tapes has usually been a component. Careful structuring of the day means we have needed only two video systems at any one time. The use of videotaped extracts obtained from television broadcasts and commercially produced tapes facilitates discussion and allows students to explore concerns and interests, including their own anxieties on becoming clinical students.[22] Nevertheless such discussion is basically passive and we have therefore used two techniques for encouraging active participation in communication.

"*Fish bowling*"—Three students take it in turns to talk for five minutes with a patient, each exploring a particular preassigned topic. Other students sit in a circle and observe—sometimes they have been asked to concentrate on a specific aspect of the interviews. Although some of the students are actively involved, the method is not close to real clinical interviewing since the patients, who have been carefully selected and briefed, are typically too helpful and students and staff are unwilling to "stretch" them.

Box 3—Role play script for introductory day

Both "doctor" and "patient" are told that the consultation might start with the lines:

Doctor: Good afternoon, Ms/Mr ________. What seems to be the problem?
Patient: Well I've had this headache for a week now and it won't go away.

Additionally the "patient" is also told the following:

You are a 20 year old history student, complaining of a headache of six days' duration. It is diffuse, moderately severe, and continuously present. You occasionally have headaches, but have not had one lasting this long before. Aspirin has not helped it. You do not suffer from migraine, and are not taking any other drugs. In the family an uncle died of a stroke about three years ago, and your father has high blood pressure. A week or two ago you read in the paper about a famous pop star who had died of a brain tumour. Your exams are six weeks away and your first year performance was adequate, although not brilliant. However, the second year has been more difficult than you expected, in part because more independent library work was required, and partly because you have had a much more active social life. You are an ambitious sort of person and would like to get a good degree so that you can get a job in the civil service. Finally, you have been going out with your current boyfriend or girlfriend for about six months, and recently things have not been going so well.

Don't tell the doctor everything in one gush. When you are asked about symptoms, tell about them. Don't be more specific than you would be if you were going to your GP with a similar problem. If you feel embarrassed about talking about a problem—or about simulating it—then be reticent and let the doctor explore carefully. If the doctor asks a stupid, crass, or insensitive question act as you would do if you were truly in a surgery. Finally, don't hide pieces of information perversely—you are not playing Cluedo!

Box 4—Important factors in small group teaching:

Setting

- Interview room (with cameras) must feel clinically appropriate
- Seminar room (with video and monitor) should be informal
- Cameras, monitor, recorder must be hard wired and permanently installed
- Video must be very simple to set up and operate
- It is useful to be able to record discussion sessions through permanently mounted cameras

Students

- Three is the ideal number
- Are anxious at first, but quickly warm up if not humiliated
- Need to be encouraged to contribute their observations to the discussion
- Rapidly "suspend disbelief" when with the simulated patient

Actors

- Are more realistic than real patients
- Provide feedback from a patient's perspective that otherwise is rarely given to students (or staff)
- Must be treated as full members of the teaching team

Scripts

- Should be detailed and carefully structured
- Actors can readily develop characters, but need clear factual information about clinical aspects

Teachers

- Tend to be overly didactic
- Tend to talk too much
- Should be sure to give positive feedback first
- Should always temper criticism with praise
- Should ensure that discussion of specific diagnostic points is relevant to aspects of communication rather than diagnosis per se

Role play—Role play has the advantage that all students are involved. Students work in groups of three: one plays a doctor, one a patient, and the third acts as observer. Students play each part in turn and therefore experience the patient's perspective as well as the doctor's. To initiate the process we provide a simple but realistic script for the first patient (see box 3), which most students are able to play without embarrassment. Students may develop other roles, based on the experiences of family or friends; we discourage complicated sets of symptoms, emphasising only the need for a clear line of narrative. Teachers move between groups, listening to role plays and sometimes commenting or suggesting that particular problems might be "rerun" in a different way. The traditional British sense of reserve can sometimes be a problem with the technique.

Video feedback sessions with simulated patients

The use of simulated patients was introduced in October 1988 so that students could develop their practical skills with individualised feedback. Teaching is intensive, in small groups, with students being videotaped while interviewing simulated patients, played by actors. The teaching provides communication skills appropriate for students during junior medicine and junior surgery attachments, emphasising history taking and information giving. Communica-

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tion is presented as not merely being a matter of being personally pleasant, important though that is, but as the central skill for successful diagnosis.[23]

Box 4 summarises some lessons we have learnt about teaching in small groups and about the use of simulated patients.

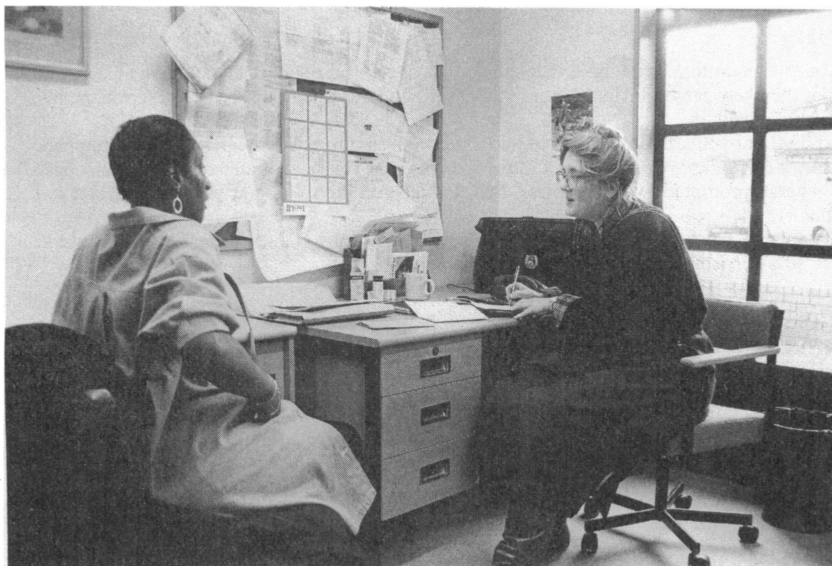
DEVELOPMENT OF SCRIPTS FOR ACTOR-PATIENTS

The sessions aim to teach communication within a realistic context of basic medicine and surgery. Scripts are written at weekend "brainstorming" sessions, with two to four clinicians and behavioural scientists, and include considerable medical, psychological, and social detail (box 4). The detail of the scripts, which are bound together into a booklet, makes it easier for actors to develop the characters. Roles are well rehearsed, initially by the clinical teachers, and subsequently by other actors, usually supplemented by watching videos of previous "patients." Actors bring a richness and depth to the characters which often surprises the scriptwriters; they are paid at appropriate professional rates and regarded as a full part of the teaching team.

It is important that all teachers understand that the purpose of the teaching is to help students develop their own skills. People, whether staff or actors, who feel that they have a specific "message" to impart are often not successful communication skills teachers. Simulated patients have a range of problems varying from abdominal pain associated with a malignant gastric ulcer, malignant hypertension due to renal artery stenosis, and ulcerative colitis to being a drug addict with subacute bacterial endocarditis and a patient without organic pathology. Their personalities vary from taciturn to unstoppably talkative, and from ingratiatingly helpful to aggressively critical. Several patients have deeper fears or worries which can be accessed if students seem supportive or interested, but otherwise will be withheld; some have common misconceptions about the nature of health, illness, and disease.

STRUCTURE OF SESSIONS

Groups typically consist of three or four students, two actors, and two teachers (a behavioural scientist and a practising clinician). Sessions last three hours and begin with a brief introduction to allay anxiety, since video feedback is often perceived as threatening. Students take turns to see a patient, and normally each student completes two or three interviews during the afternoon, each lasting between five and 10 minutes. Going first is stressful, and the first patient is therefore straightforward. In their first interview students gather information for making a diagnosis, aiming for an orderly, efficient manner that is sensitive to the patient's needs and concerns. They are asked not to take a detailed "systematic history," but simply to obtain the most salient information. Time restriction helps prevent rambling, unstructured interviews and focuses attention on the specific task. In the second interview the emphasis is on giving information, for instance about an endoscopy or other procedure. Before each second interview students and teachers anticipate and discuss possible difficulties. The third interview usually concerns more sensitive topics and here an awareness of the patient's emotional state is crucial to successful communication (box 5). All interviews are observed on a television monitor by the other students and teachers.



SALLY AND RICHARD GREENHILL

FEEDBACK AND DISCUSSION

After each interview the student and the patient return for feedback and discussion, lasting 10-20 minutes. The discussion starts with the student giving his or her impression of the interview, and the actor then provides direct feedback. Actors often discuss how the "patient" may have responded to particular approaches, and they provide a patient's perspective on medical issues. The specific diagnosis is always discussed at some point, but the emphasis is on the technique of the interview. Common topics are the missing of important information, missed opportunities to ask questions, ambiguous replies, and cues from tone of voice about other problems. Many other details will also emerge, such as the role of body posture or eye contact. Feedback is encouraged from the actors and other students, and the teachers try to ensure that students receive positive feedback about what has been done well. Often the students' harshest critics are themselves, and they need reassurance that they are doing things well, at an appropriate level for their experience. Interviews are recorded in their entirety, but only short extracts are replayed to highlight specific points raised in discussion. Teachers keep notes on the timing of interesting parts of the interview so that the tape can be rewound to appropriate points. Having two teachers greatly assists this since one teacher can control the video while the other maintains the discussion. Slow motion, freeze frames, fast forward, and playback without sound can all be used with great effect to emphasise aspects of non-verbal communication.

The teachers—Good communication skills teaching requires good teachers, and that requires training of the teachers themselves. At present our training is extremely limited, although we have held weekend discussion sessions which have focused the attention of teachers. An important insight was gained when two teachers were themselves videotaped as a part of the BBC TV series *Doctors To Be*. Replaying the tapes reinforced the well known but still invaluable lesson that medical teachers talk too much and are too didactic. The techniques used to improve students' skills can also benefit teachers' skills, and we recommend that purpose built teaching facilities should allow for the routine video recording of discussion sessions as well as interviews, for the subsequent teaching of teachers.

Evaluating our teaching

Our evaluations (box 6) suggest that medical students enjoyed and benefited from introductory teaching in communication skills and that there is a substantial demand for further teaching. Indeed, students have specifically suggested further topics:

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breaking bad news to patients and relatives; dealing with embarrassing questions such as on sexuality or drug use; communicating with the young and with very old patients, and with patients who have speech or hearing problems or are not fluent in English; and dealing with difficult patients—such as those who are angry, cynical, anxious, talkative, abusive, or in tears. Such interest suggests that teaching has influenced attitudes towards communication in medical practice. Although as yet we cannot know the long term effect of teaching communication skills, there is reason to believe that it will be positive.[8 24 25]

Successful teaching seems to require participation of students, in particular the use of active critical discussion and role play in the introductory day, and interactive video feedback with simulated patients. Video seems to us to be particularly important as students would otherwise rarely see themselves interviewing or see others interviewing. Staff and students agree that the use of actors is a fundamental part of the teaching. Actors give a flexibility and sophistication in teaching that role play or real patients cannot possibly provide. Students often comment on the extraordinary realism of the interviews with actor-patients.

HURDLES TO BE OVERCOME

Medical school timetables are overcrowded, and finding space for a new and unusual course is not easy. Extension of teaching not only requires curriculum time and release of students from clinical attachments but also additional commitments of time from teaching staff. We are fortunate in having senior and junior hospital teaching staff who wish to take part in the teaching; the medical school's continuing commitment has been shown by the appointment of a full time lecturer in communication skills. We are in little doubt that a full time teacher is essential, not only for organising students and actors and for teaching the teachers but also to have a visible presence and thereby to act as a catalyst and coordinator for other communication initiatives within the school.

THE FUTURE

If communication teaching is to continue to develop then students' skills must be formally assessed. The minority of students who choose not to attend the teaching may be those particularly in need of assistance. At present, final examinations do not assess ability to communicate but assessment can also be carried out as an integral part of the course providing direct feedback to students of their competencies. Formal evaluation probably requires an interview with a simulated, standardised patient; medical school staff can rate communicative ability and adequacy of

Box 5—An (abbreviated) example of a script provided for an actor

Actors receive information on the background, medical history, and personality of the patient.

Background—Mrs Morgan is a 43 year old married woman who is usually in reasonable health. She has been married for 20 years and has three teenage sons. Her husband is the manager of a garden centre; she works part time in a shop. She tires easily and worries about whether she is looking after her family well enough.

Medical history—Recently she has been getting more and more tired. She hasn't felt right since having a wisdom tooth out. Yesterday afternoon she fainted at home. Her son called the GP, who arranged an immediate admission to hospital. Actor describes: tiredness; pain/aching in left side, just above the waist; fainting, suddenly with little warning. If asked actor can provide the following information: rheumatic fever as a child; no other serious illness; dental treatment one month ago; wisdom tooth extraction; last pregnancy was difficult—they kept listening to her heart and induced labour at 36 weeks. She does not smoke and drinks only socially.

Personality—Mrs Morgan is a pleasant lady who wants to help the doctors. However she is nervous, and when nervous can get a bit muddled. She may confuse dates, or go back and correct something she said. In the first interview she is inclined to dismiss the idea that she may be ill. "I just fainted, that's all." Later on she is more worried. She responds gratefully to being reassured, but it doesn't last long. Something else will come into her mind to worry her.

Before each interview there is a briefing for the student (given verbally) and one for the actor (who will have studied the script, and developed the character, before attending the teaching session). There are also written notes to emphasise the focus of the session, and its teaching objectives.

First interview

Briefing for student—Mrs Morgan was admitted after fainting at home and so far little else is known. She's a pleasant lady, but a bit nervous.

Briefing for actor—She is pleasant, wants to be helpful, but apt to wander off the point. She plays down the fainting episode, says she feels a bit weak, but wants to go home.

Teaching focus—Mrs Morgan is anxious to help the doctors and the first interview is straightforward. The student should at least suspect that she has bacterial endocarditis.

Second interview

Briefing for student—You have to explain to Mrs Morgan that she is to have echocardiography, and why. This should also involve some explanation of the likely cause of Mrs Morgan's symptoms. The clinician will briefly describe the test if the student is not sufficiently familiar with it.

Briefing for actor—Listen and nod, but you are too inclined to nod when you do not really understand. A bit too keen to please and not be any trouble. The student needs to check quite carefully that you have understood. You may have questions, but they are more general, prompted by nervousness. People keep coming to look at your fingers, and feel your tummy. Why do they do that?

Teaching focus—The student explains that Mrs Morgan has to have echocardiography. This is primarily an exercise in clearly explaining a common test to a worried patient with no technical knowledge.

Third interview

Briefing for student—You have to explain the results of the tests and the diagnosis. Mrs Morgan will have to remain in hospital for perhaps a month, and receive intravenous antibiotics every six hours through a cannula.

Briefing for actor—You are now confused and distressed but realise that the illness is serious. You are horrified at having to stay in hospital: who will look after my family? Does this thing [the cannula] have to stay in my wrist all that time? You are less worried about yourself than about your family, who are probably quite capable of managing. It doesn't seem to occur to you that they will care more about you getting well than about having to cook for themselves.

Teaching focus—The student explains the diagnosis and tells Mrs Morgan that she has to stay in hospital for a month. Mrs Morgan is distressed and worried about her family. The student has to cope with this and reassure her but also emphasise that she must remain in hospital.

Box 6—Evaluation of teaching: summary of results

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Introductory day

Between 1986 and 1991 332 forms were returned, a 65% response rate. The course as a whole and its components were generally seen as successful. Most students (65%) found the day more interesting than expected, became more interested in doctor-patient communication (75%), and became more interested in their own behaviour (88%).

Component of course	% Of students responding: Very successful	Moderately successful	Not very successful	A waste of time
Overall	37	61	2	
Lecture (am)	26	61	11	2
Video observation (am)	28	59	10	3
Discussion of videos (pm)	51	40	8	1
Role play/fish bowl (pm)	53	37	9	1

Simulated patients

Responses of 124 students between 1988 and 1991 show that students found the teaching realistic and very useful; 94% of students would like more of this type of teaching.

	% Of students responding: Very	Quite	Not very	Not at all
Overall, how useful did you find the afternoon?	80	20	–	–
How realistic were the actors' portrayals of patients?	88	12	–	–
How useful were the comments of the teachers?	62	38	–	–
How useful was the feedback from the actors?	68	31	1	–

medical content, and the trained actor-teacher can rate students from the patient's perspective. Naturally such assessments are not cheap in terms of the resources needed. They are probably best implemented by a skills lab[26] or an objective structured clinical examination.[27]

The 1990s will be the decade in which the teaching of communication skills becomes a normal part of the training of all medical students and of examinations for membership of the royal colleges. The General Medical Council has recommended that there should be a final year assessment of each student's ability to communicate effectively with patients.[28] The Royal College of General Practitioners has carried out such assessments for several years, and the Royal College of Physicians has "instructed their examiners to devise ways of testing the ability of young doctors to communicate with their patients"[29]; it is probable that the other colleges will follow suit. The new cohorts of junior doctors will need experience of communication teaching during undergraduate training and will expect it at postgraduate level. We have little doubt that medical schools will wish to provide such training.

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SUGGESTIONS TO AUTHORS

Wordsworth looks at the psychological development of the infant

Blessed the infant babe
For with my best conjectures I would trace
The progress of our being—blest the babe
Nursed in his mother's arms, the babe who sleeps
Upon his mother's breast, who, when his soul
Claims manifest kindred with an earthly soul,
Doth gather passion from his mother's eye.
Such feelings pass into his torpid life
Like an awakening breeze, and hence his mind,
Even in the first trial of its powers,
Is prompt and watchful, eager to combine
In one appearance all the elements
And parts of the same object, else detached
And loathe to coalesce. Thus day by day
Subjected to the discipline of love,
His organs and recipient faculties
Are quickened, are more vigorous; his mind spreads
Tenacious of the forms which it receives
In one beloved presence.

William Wordsworth (1770-1850),
The Prelude (1805 version), Book II, 237-55.