

## Teaching Medical Communication Skills: A Call for Greater Uniformity

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**Background and Objectives:** Evidence suggests that strategies used in teaching communication skills vary widely among, and within, medical education programs. Such variance also exists in the amount of emphasis placed on specific communication skills. This study examines the degree of variability among medical faculty in identifying opportunities for teaching communication skills. **Methods:** Sixty-seven medical faculty (physicians and behavioral scientists) reviewed a videotaped interview of a clinician with a standardized patient. Using a transcript of the interview, participants identified moments in the tape they believed warranted an instructional intervention to reinforce or modify the clinician's communication skills. Items identified by the participants were compared to items identified by a panel of experts. Frequencies and ANOVAs were used to report on consistency and on consistency as a function of faculty experience and educational background. **Results:** Faculty demonstrated marked differences in identifying teachable moments across all six communication categories: (1) rapport building, (2) agenda setting, (3) information management, (4) active listening for the patient's perspective, (5) responding to emotion, and (6) skills in reaching common ground. Of 67 respondents, 29.6% identified none of the opportunities to teach rapport building, while only 31% identified all opportunities; 32.8% identified none of the information management opportunities, 26.9% identified all; 77.6% failed to identify the agenda-setting opportunity, 22% did identify the opportunity; 25.4% identified none of the active listening opportunities, 9% identified all; 57.6% identified none of the responding to emotion opportunities, 18% identified all; 35.8% did not identify the opportunity for reaching common ground, 64% did identify the opportunity. **Conclusions:** Our findings demonstrate that faculty who teach communications vary widely in the issues that they identify and about which they chose to teach. Recommendations are made for further research in this area.

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The Association of American Medical Colleges recently recommended the teaching and assessment of communication skills throughout medical school and residency.<sup>1</sup> Experts agree on the importance of faculty development to enhance this teaching.<sup>2-5</sup>

Recognition of the need for faculty development grows in part from an abundant literature documenting the poor inter-rater reliability of faculty who assess communications.<sup>6-8</sup> It appears that without special efforts, different faculty look at the same communication and interpret it from different perspectives. Kalet et al found inter-rater reliability among faculty to be

low in identifying specific interviewing skills among medical students.<sup>9</sup> Kalet et al also concluded that faculty tended to rate students based on likeability, rather than on specific, objective interviewing skills. Stillman compared evaluations of residents' interview performances made by faculty with those made by nonfaculty. Inter-rater reliability was disappointingly low for both groups, and faculty were no more likely to agree with other faculty than with a nonfaculty rater.<sup>10</sup> Results were similar in other studies with similar designs; inconsistent, nonuniform assessment by faculty appeared to be the rule.<sup>11</sup>

What is necessary to achieve uniformity of teaching and assessment in communications? First, there needs to be a consensus about what is important. Consensus statements from Toronto and Kalamazoo provide such

information.<sup>2,4</sup> The Toronto Consensus identified “the most important things that could be done now to improve clinical communications.” These include physician-patient encounters in which patients get to identify all of their agenda items and concerns, eliciting patients’ perspective on illness and addressing feelings with empathy, information management (including appropriate use of open-ended questions and summaries), and the ability to negotiate to arrive at common ground. In addition to reemphasizing these skills, the Kalamazoo Consensus listed rapport building as first among essential skills.

Faculty next need to develop the ability to identify when these skills are performed, missing, or poorly performed. Finally, faculty need to acquire a set of instructional skills that are effective over a wide range of teaching situations, with widely varying communication performances and with learners who perform well and with those who perform poorly.

This article focuses on faculty’s ability to identify important “teachable moments” that reflect the growing conceptual agreement around core communication skills. In doing so, it provides a model with which to provide faculty development in the teaching of communication skills that can serve as (1) a point of reference for other efforts and audiences and (2) a challenge that identifies areas of uniformity building that need attention.

## Methods

In 1994, as part of a faculty development effort at East Tennessee State University, we developed a set of videotapes that incorporated examples of the core communication skills that were emphasized by the Toronto Consensus report. These interviews demonstrated teachable moments that reflected the performance, nonperformance, or poor performance of each of the following core communication skills: (1) rapport building, (2) agenda setting, (3) information management, (4) active listening for the patient’s perspective, (5) responding to emotion, and (6) skills in reaching common ground.

Eighteen teachable moments were originally scripted into the interview used in the present study. To establish a standard against which to compare participants’ responses, the interview was reviewed by 10 expert faculty with extensive experience teaching medical communications faculty development workshops. If concordance among experts was less than 40% in the interpretation/scoring of any section of the videotaped interviews, that section was excluded. By this criterion, 13 sections of the videotaped interviews were used in this study. Each of these sections demonstrates a communication issue potentially warranting an educational intervention. The 13 points are detailed in Table 1.

A slightly modified version of the interview was then used in three stand-alone workshops titled “Teaching Patient-centered Communication—Faculty Development Workshop,” which were held in 1997–1999. The videotaped interview, involving a patient with leg pain, was distributed to participants prior to these workshops. Participants were asked to observe the entire 5-minute interview without stopping, as if they were observing the learner in their teaching clinic, then spend no more than 5 minutes identifying moments around which they would provide an educational intervention (ie, instructive feedback) to the learner. They were given a transcript of the interview (see Appendix 1) and asked to underline all the points in the transcript they believed warranted feedback to the learner and provide brief annotation to identify how they might provide that feedback. Instructions were kept brief to allow for participating faculty to use their own approaches to feedback. (Readers who wish to use this article to compare their choice of teachable points with the experts and with workshop participants should turn to Appendix 1 at this time before reading the results of the study.)

## Data Analysis

Two investigators independently scored whether each of the respondents identified each of the 13 sections of the interview warranting intervention. Frequencies were generated regarding whether or not participants noted each of the 13 teaching points. Frequencies were also generated regarding whether the observer would provide feedback that was positive (noting skills performed well) or negative (noting omissions or misperformance.)

A one-way ANOVA was performed contrasting faculty discipline (MD versus PhD/EdD versus other) along the six core skills mentioned previously and positive and negative feedback. A one-way ANOVA was performed contrasting faculty experience along the six core skills and positive and negative feedback. Pearson’s *r* was calculated for all pairs of core skills and positive versus negative feedback.

## Results

Of 90 faculty participants at these three workshops, 67 submitted annotated transcripts. Table 2 shows participant demographics in terms of professional degree, experience, and gender.

Table 1 categorizes each of the teachable moments by the core skills demonstrated and notes whether it was performed well or poorly. It depicts the percentage of experts and subjects identifying occurrences of each of the 13 teachable moments. Table 3 breaks down results by each of the six core skills, showing the percentage of participants who identified teachable moments within each category of core skills (from responding to none to responding to all opportunities).

Overall, participants made significantly more negative than positive comments about the learner's performance in the vignette. Nearly one third of the participants noted none or only one positive comment, while 56% made six or more critical comments. MDs identified more occurrences of agenda setting than those in other disciplines ( $F=3.979, P=.024$ ), but there were no significant relationships between disciplines and the number of comments regarding the other five core skills and positive or negative feedback.

ANOVA comparing participants of different experience levels on number of comments regarding the six core skills and positive and negative feedback showed no significant relationships.

In looking at the degree of correlation between core skills ratings by faculty, only rapport building and agenda setting ( $r=.345, P=.004$ ), and rapport building and information management ( $r=.386, P=.001$ ) were significantly correlated. None of the other core skill items were significantly correlated.

Table 2

Demographics

	#	% of Sample
Degree		
MD/DO	34	50.7
PhD/PsyD	19	28.4
Masters	13	19.4
Not reported	1	1.5
Experience		
Extensive	10	14.9
Moderate	34	50.7
Occasional	10	14.9
Little/none	6	9
Not reported	7	10.4
Gender		
Female	36	54
Male	31	46

Table 1

Teachable Moments in the Vignette As Identified by Experts and Subjects

Core Skill Represented	Performance Quality	Concordance % Among Experts (n=10)	% of Subjects Noting TM (n=67)	Line Numbers*
Rapport building	Good	100	68.7	1-12
Active listening	Omission	40	22.4	15-18
Agenda setting	Poor	40	22.4	18-19
Active listening	Omission	90	65.7	27-29
Responding to emotion	Omission	90	14.9	27-29
Information management	Poor	60	52.2	35
Active listening	Omission	70	53.7	46-51
Responding to emotion	Omission	70	17.9	48-51
Information management	Good	100	41.8	51-55
Active listening	Omission	70	46.3	65-67
Rapport building	Good	70	38.8	74
Common ground	Omission	70	64.2	106-123
Active listening	Omission	50	41.8	118-120

TM—teachable moment

Discussion

Since consensus is only recently developing among experts in teaching medical communication, it is of little surprise that the results of this study show poor consensus among faculty on what they identify as important teachable moments in a medical interview. If faculty believe that a consistent teaching message is important in influencing students' and residents' behavior, then these findings should charge programs to explore means by which to effectively develop programmatic consensus and uniformity in teaching communication skills.

Table 3

Percentage of Subjects Identifying Occurrences of Each Core Skill

Core Skill	# of Occurrences in Tape	Percentage of Subjects Identifying # of Occurrences*					
		0	1	2	3	4	5
Rapport building	2	26.9	41.8	31.3	—	—	—
Agenda setting	1	77.6	22.4	—	—	—	—
Information management	2	32.8	40.3	26.9	—	—	—
Active listening	5	25.4	13.4	17.9	17.9	16.4	9.0
Responding to emotion	2	57.6	24.2	18.2	—	—	—
Common ground	1	35.8	64.2	—	—	—	—

\* Shows % of subjects identifying one, two, three, four, or five occurrences of a core skill

The importance of rapport building is uniformly acknowledged. Yet a minority of faculty participants identified both opportunities to comment about this area. One explanation is that the interview depicted several positive examples of well-performed rapport-building skills. It is possible that faculty fail to see positive reinforcement of well-performed skills as important teachable moments. If this is true, such a bias may represent an even greater problem in teaching of communications skills.

It is of interest that while 72% of the participants identified rapport skills when demonstrated early in the interview, only 25% identified the positive supportive comment later in the interview. It appears that current teaching and evaluation of rapport building may focus only at the beginning of an interview while later opportunities are overlooked.

The dichotomous assessments made by different faculty looking at exactly the same rapport-building interactions in lines 1–12 (Appendix 1) represents a particularly disturbing finding. Most who responded thought that the interaction was worthy of positive note, but others saw it as notably inadequate or negative. When students discuss their experiences and realize that different faculty provide contradictory advice, course credibility suffers.

Only a small number of faculty and less than a majority of the experts identified a classic transition from agenda setting to doctor-centered questioning after 18 seconds of the interview. Instructors may be attending to points in the interview where the interviewer interrupts the patient in mid-statement, rather than noting the shift of control from the patient's agenda to the interviewer's.<sup>12-14</sup>

The low percentage of response to the examples of information management can only be partially explained by the confounding variable of one of the examples being a well-performed summary. The interview also included a verbal interruption in which the physician interrupted an important patient statement to ask another specific closed-ended question. Only 42% of the sample noted the interruption on line 34.

Active listening opportunities included only examples of missed opportunities. The interview provided a total of five examples of the patient implying, but not stating, additional personal meaning or concern, thus providing numerous opportunities for active listening.<sup>15</sup> Only 43% of participants identified half or more of these missed opportunities. This number likely overestimates general faculty ability to identify opportunities to teach active listening, since those choosing to attend our workshop had at least some familiarity with a patient-centered model that emphasizes exploring of patients' ideas, concerns, and expectations.

The low percentage of participants who would have chosen to provide an educational intervention regard-

ing the missed strong feeling statements is striking. It should be noted that a number of participants would have responded to these expressed feelings by encouraging the interviewer to explore the meaning of the symptoms to the patient. Such exploration (while not directly acknowledging the feelings) would likely have functionally addressed the patient's concerns. On the other hand, had the opportunities for addressing feelings been more subtle or limited to contextual clues implying feelings, even fewer of the faculty would likely have addressed them as teachable moments.

Only recently has there been emphasis on developing skills necessary to reach common ground when opinions and positions of physician and patient are divergent or opposed. Because of this, it is not surprising that many faculty failed to identify the persistent differences of perspective and expectations between the patient and physician. Perhaps because the patient was not defiant, oppositional, or in any way antagonistic, the faculty may not have identified the disagreement about the plan at the end of the interview (Appendix 1, lines 104–123). Additionally, in terms of teaching methods, the videotaped interview used in this exercise was designed to provide opportunities for both positive reinforcement and constructive criticism. The majority of participants focused on moments in the interview that are flawed. Thus, future investigation of the effects of negative versus positive reinforcement when teaching communication skills is warranted.

It is reaffirming that the great majority of teachable moments identified by participants fell into one of the six categories used in this study. While faculty did not all identify a common set of teaching moments, there are not many identified teachable moments which are not easily categorized within these six skills. If additional research and expert opinion affirms the importance of these six skills as distinct and that each contributes to the overall performance of an effective interview, medical communications will be at the beginnings of teaching and evaluating uniformly.

#### Limitations

The conclusions of this study are limited by at least two methodological issues. First, one must consider that the international panel of faculty experts may not have been the ultimate gold standard. Their assessment, while more consistent than that of the participants and more consonant with a patient-centered interviewing model and with the Toronto Consensus Statement, is not directly evidence based. Second, faculty attending the workshops at which data were gathered were not randomly selected. Only faculty with specific interest in the patient-centered communication participated. As such, faculty in this study may not be representative of other faculty who teach communications. Indeed, given the shared interest in patient-centered communication,

it should be expected that faculty attending these workshops might demonstrate more consistency than would randomly selected faculty.

### Conclusions

Potential limitations notwithstanding, the poor consistency and uniformity of communications teaching content demonstrated by faculty participating in this study are striking. Results of this study suggest that future research should investigate methods by which to identify and overcome barriers to poor consistency and uniformity. Evaluations of how clearly faculty define and identify communication skills they choose to emphasize and how closely those choices parallel the skills identified by the Toronto and Kalamazoo Consensus statements could be helpful. Additional efforts at documenting the effectiveness of faculty development in enhancing the uniformity and quality of communication teaching may also prove valuable.<sup>16-18</sup> When what we teach and how we teach it, from medical school to residency, from discipline to discipline, from conceptual model to conceptual model, all begin to overlap, the field of communication will finally have come of age.

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## Appendix 1

## Using This Article as a Personal Faculty Development Communications Exercise

Directions: Please read the transcript quickly without pausing. Imagine you are observing a learner in your clinic for the purpose of providing feedback. After reading it, consider those points in the interview warranting instructional intervention. Then spend no more than 5 minutes underlining teachable moments. Briefly describe the points that you would address. When complete, turn to the text of the article. (Note to readers: if you wish to "test" yourself to see if you identify the same teachable moments as the experts, cover the right-hand column while conducting the exercise.)

**Patient With Leg Pain  
(Mrs Jones)**

Background: Mrs Jones is a patient known to the clinician. She has scheduled an appointment because of "pains in her leg."

<p>1 CL: Hi, Mrs Jones. How're you doing today? 2 3 PT: Well, I'm okay, thank you. 4 5 CL: Well, good. The last time you were in here you told me you were 6 looking for a job. How's that going? 7 8 PT: Well, I got a job. It's at a good university. I work in the English 9 Department doing some editing work and reviewing student 10 papers. It's going really well. 11 12 CL: Well, good. Good. What brings you in today? 13 14 PT: Well, I've been having this pain in my leg for the past 3 or 4 weeks. 15 It's down here in my lower leg and just aches deep. Well, it seems 16 to me that it's coming from inside. 17 18 CL: So you've been having this aching pain in your leg for 3 or 4 weeks. 19 When do you get it? 20 21 PT: Well, it comes on at different times. But, um, it's usually in the 22 evenings when I'm just laying around the house or sometimes when 23 I'm laying in bed, it really aches. 24 25 CL: So, when you get this pain, what's it like? 26 27 PT: Well, it's not that it's too severe, but I'm kind of upset about it. 28 29 CL: How long does it last? 30 31 PT: Well, they usually last about a half hour to an hour. I usually take a 32 couple of Advil, and that makes it go away. Could I be taking too 33 much Advil? Because I'm not sure if it's the Advil . . . 34 35 CL: Well, how much are you taking? 36 37 PT: Well, taking, hmm... I guess two Advil every couple of days. But there 38 have been days where I've taken two Advil twice in the same day. 39 40 CL: Well, if you don't have any stomach pain and no history of ulcers, 41 well, that amount of Advil should be fine. What else is related to the 42 pain in your leg? 43 PT: Well, nothing I can think of. I do exercise regularly, but the pain 44 doesn't seem to come on when I'm jogging. It's more in the evening 45 when I'm just relaxing. Now, I've kind of paid attention to the leg to 46 see if something else happens with the pain, but there doesn't seem to 47 be any redness or swelling. I just have, kind of, been concerned 48 about what could be causing the pain. 49 50 CL: Let's review your story here. You get an aching pain in your leg, 51 sometimes every day, sometimes every other day for the last 3 or 4 52 weeks, and this pain lasts 30-60 minutes, and it goes away with 53 some Advil, and you've not noticed any redness or swelling when 54 you have this leg pain. Is there anything else? 55 56 PT: No, that's about it.</p>	<p>Lines 1-12: Good rapport building</p> <p>Lines 15-18: Missed opportunity for active listening</p> <p>Lines 18-19: Incomplete agenda setting</p> <p>Lines 27-29: Missed opportunity to address feelings and to explore patient's ideas about the illness</p> <p>Line 35: Interrupts patient's information flow</p> <p>Lines 46-56: Missed opportunity to explore patient's ideas about the illness</p> <p>Lines 48-51: Missed opportunity to acknowledge feelings</p> <p>Lines 51-55 Well-done summary</p>
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## Appendix 1

(continued)

<p>57 CL: Does anything other than Advil help to relieve that pain? 58 59 PT: Nothing I can think of. But, it's either the Advil or just time that 60 makes it go away. 61 62 CL: Does anything bring the pain on? 63 PT: No, nothing I can think of. I'm not usually doing anything in particular 64 or in a certain position. I just wish I knew what was causing the pain. 65 66 CL: Well, I understand. Let me ask a few more questions, and we'll try 67 to figure this out for you. You mentioned earlier that you jog. Why 68 don't you tell me about your jogging and your exercise. 69 70 PT: Well, I've been feeling really good about my jogging. I used to jog 71 about a mile very slowly about three times a week. But, now I've 72 increased and got into my first 5K race 2 weeks ago, and I did really 73 well in my age group. 74 75 CL: Well, that's wonderful. Congratulations, that's great. So, how many 76 miles, total, do you run in a week? 77 78 PT: Well, about two or three miles about five times a week. 79 80 CL: Okay, so, you've gone from running about three miles a week 81 to about 12 or 15 miles a week? 82 83 PT: Mmm hmm. 84 85 CL: That's a lot of running. 86 87 PT: Yeah, and I'm less out of breath like I used to be. 88 89 CL: Well, good. You've been doing a lot of conditioning. So, why don't I 90 take a look at your leg now, and we'll try to get to the bottom of this. 91 92 93 (Clinician examines patient and returns to the consultation room.) 94 95 CL: Your physical is normal. I couldn't find anything wrong with your 96 skin, muscles, or your blood vessels. So, I think that this pain is 97 coming from what we call over-use syndrome. This happens when 98 you change your exercise drastically in a short period of time, and 99 the joint and your muscles get overworked, and you get some swelling 100 and the swelling causes the pain. What condition are your running 101 shoes in? 102 103 PT: Well, I run in Nikes, and they are a little worn in the heels. 104 105 CL: All right. I suggest that you pull back on that running some and 106 don't do more than 10 miles total each week. Okay, you probably 107 need to replace your shoes. Sometimes, with a worn heel, it can 108 cause some extra strain on your muscles and your joints and help 109 cause this kind of pain you've been having. As you increase your 110 running, I suggest you do that very slowly. Change it only a mile 111 per run every month. So, in other words, if you run two miles every 112 time you run, then do that for at least a month before moving up to 113 two miles per run or even three miles per run. If, when you increase 114 your running, and you get this pain again, then you need to slow 115 down some. All right? Do you have any other questions? 116 117 PT: Do you think I should have an X ray? 118 119 CL: Well, no. I don't think you need one at this time. 120 If the pain continues, just let me know. 121 122 PT: Okay.</p>	<p>Lines 65–67: Missed opportunity to explore patient's ideas about the illness</p> <p>Line 76: Well-done rapport building</p> <p>Lines 106–123: Failure to reach common ground</p> <p>Lines 118–120: Missed opportunity to explore patient's idea about illness</p>
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**Resources for group faculty development:** If you are interested in using the videotaped interview as part of faculty development at your institution, please e-mail or write the authors, who will provide the videotaped interview and transcripts on NCR paper.