

Cultivating Patient-Centered Communication Skills Training Across the Medical Education Continuum: A Model for Practice

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Effective patient-centered communication improves trust, patient satisfaction, health literacy, and health outcomes and reduces health disparities and law suits that occur due to poor communication.¹⁻³ For these reasons competency guidelines outlined by the Accreditation Council for Graduate Medical Education,⁴ the Liaison Committee on Medical Education, Accreditation Review Commission on Education for the Physician Assistant,⁵ and the Association of American Medical Colleges⁶ require that communication skills training be mandated in undergraduate and graduate medical education. The Institute of Medicine of the National Academies report “Improving Medical Education” concluded that basic and complex communication skills are a “high priority”² in medical education.

Despite growing evidence that patient-centered care improves health outcomes, medical students receive mixed messages.⁷ In preclinical communications courses in US medical schools, educators use available evidence to teach students to be open, reflective, and patient-centered, while in clinical clerkships students often witness directive, doctor-centered

communication by those who have not had the training that current students receive.^{8,9} At Wake Forest University School of Medicine Department of Family and Community Medicine our goal is to cultivate culturally competent, patient-centered communication skills across the continuum of medical education to more effectively address health literacy needs, reduce health disparities, and improve health outcomes. Since 2000, 5 Title VII

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Health Resources and Services Administration grants have facilitated the development of a culturally competent, patient-centered communication curriculum for faculty, family medicine residents, and medical and physician assistant (PA) students. Each grant was envisioned as a step towards the long-range process necessary to create patient-centered teachers, clinicians, and students. This article presents an overview of curricular innovations, the

evaluation process, early outcomes, and next steps.

The curriculum across learner groups (faculty, residents, medical and PA students) was developed using Common Ground,¹⁰ a criteria-based training model derived from the Kalamazoo Consensus Statement.¹¹ This model was adopted for

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its ease of use in the clinical setting and for the associated Common Ground Assessment Instrument (CGAI) which has construct validity, internal consistency, test-retest reliability, and generalizability across clinical cases.¹⁰ The model includes 6 core skills: rapport building, agenda setting, information management, active listening, addressing feelings, and reaching common ground. The curriculum was incorporated into faculty development, residency training, and medical student training in the Department of Family and Community Medicine and also into the curriculum of the Department of Physician Assistant Studies. The following sections describe the activities into which the curriculum was included.

Department of Family and Community Medicine Activities

Faculty Development

An Administrative Units award provided infrastructure support for patient-centered communications research and funded 6 faculty pilot projects. Outcomes of this grant led to several other communications research projects including 2 National Cancer Institute grants, and to numerous presentations, publications, and curricular innovations.

Residency Training

A residency training award facilitated development of a cultural competency curriculum for residents and medical Spanish and immersion training in Guatemala for faculty, staff, and residents. It also fostered ties with 2 Latino clinics. Outcomes of this grant included the addition of 20 hours of communication skills training provided during the Human Behavior Rotation for first-year residents. Evidence indicates mindfulness training may improve a physician's self-awareness and other-awareness, help decrease anxiety, and help develop a relaxed alertness that might contribute to the incorporation of communication skills in clinical practice.¹²⁻¹⁴ The new training includes (1) relaxation/ mindfulness training and practice including an examination of their roles in development of higher order communication skills; (2) introduction to and practice with the CGAI; and (3) videotape reviews of residents' patient encounters using the CGAI. Common Ground skills are reinforced during the required geriatric outpatient rotation in the second year. During the second and third years, residents attend a Balint support group which provides an opportunity to consider how patient-centered communication can facilitate patient care.

Medical Student Curriculum

A predoctoral training grant allowed us to develop a collaborative project with the Departments of General Internal Medicine and Pediatrics to implement a communication skills curriculum in 3 third-year clerkships. This grant facilitated a continuity experience for clinical students to further develop and refine patient-centered communication skills taught in the preclinical years to better serve diverse and vulnerable patient populations.

We worked with the course and clerkship directors to revise the first-year communications course and with the family medicine clerkship patient simulation to reflect the Common Ground skills. All evaluation instruments and the interview skills template used by the students are explicitly linked to the Common Ground skills domains. Three new standardized patient assessments focusing on vulnerable and high-risk patients were designed for and implemented in the third year ambulatory care clerkships. In the last 2 years we trained nonfaculty raters to reliably assess students' communication skills using the Common Ground criteria.

Outcomes of this grant led to the training of over 90 faculty, nonfaculty, and community preceptors as raters to reliably assess communication skills throughout 4 years of the curriculum. Use of the CGAI has helped to ensure that we are evaluating communication skills objectively across multiple assessments in preclinical and clinical years. To evaluate effectiveness of the communications curriculum, the trained nonfaculty raters were randomly assigned student interviews from the standardized patient assessments to rate. To date, they have reviewed over 3000 videotaped interviews to find that skills have significantly improved across 3 classes of first-year medical students. The next step is to evaluate longitudinal data which include a total of 14 digitally recorded video encounters per student from baseline to graduation.

Department of Physician Assistant Studies Activities

A recently completed grant established a culturally competent, patient-centered curriculum. For first-year students, core communications elements were incorporated. Students are oriented to Common Ground while reviewing DVDs of clinician-patient dyads using the CGAI. In small groups, students practice using patient-centered skills with standardized patients. To further improve communication skills students participate in a required medical Spanish course and are trained and evaluated on effective use of medical interpreters. Eight standardized patient assessments over both years and site visits in the clinical year are used to evaluate these skills. Outcomes include (1) significantly improved patient-centered communication skills across the last 2 classes (nonfaculty raters have reviewed over 1000 randomly assigned recorded interviews); (2) effective student interaction with interpreters and an increased student ability to use medical Spanish in the clinical setting; and (3) completion of an international Spanish language immersion program by 17 students.

Because we know there is no one factor more predictive of poor health status than low health literacy,³ the current grant is devoted to integrating health literacy throughout both years (preclinical and clinical) of training; this new component will be embedded in the well-established patient-centered communications curriculum within the clinical applications and professionalism courses. Skill 6 of the Common Ground model trains learners how to (1) summarize the patient's problems and concerns; (2) check for understanding; (3) check for feasibility; (4) check for agreement;

and (5) establish mutual responsibility for the plan. Using this guide, students will consider health literacy as well as cultural, financial, and other factors as they develop a plan with the patient that effectively ties the visit to what happens when the patient leaves the office. Among other teaching strategies, standardized patient instructors (portraying patients who need to stop using tobacco or alcohol, lose weight, exercise more, or manage diabetes) will provide the students with multiple opportunities to practice and receive feedback (using validated instruments) to further develop these skills to care for patients in the clinical year. All students are required to review and self-assess their video recorded encounters after they receive feedback from the standardized patient assessments to improve future performance. These skills will be assessed and reinforced during site visits and standardized patient assessments in year 2 on at least 4 occasions.

Conclusion

Common Ground is highly transportable. Currently, among others, it is used in the California medical schools. We have trained faculty at other medical schools and physician assistant programs in North Carolina and Virginia. The model and its associated criteria-based instrument make it feasible to provide basic training for faculty in about 4 hours. With schools looking for ways to provide communication skills training in undergraduate and graduate medical education, this model offers an ideal method to incorporate patient-centered

communication into clinical training programs. Health Resources and Services Administration or other medical education funding to incorporate this curriculum is helpful, but not essential because the model and curriculum materials lend themselves to relatively short training.

Future goals of the Wake Forest University School of Medicine include translating these curricula and outcomes to other health disciplines, providing an advanced communication skills elective for fourth-year medical students, and developing patient-centered communication curriculums for practicing clinicians to address health literacy assessment and use. Goethe wrote, "Knowing is not enough; we must apply. Willing is not enough; we must do." Growing evidence suggests that we are not applying what we know and are failing to provide adequate care for millions of patients in a country with the most expensive health care system in the world using doctor-centered models of care.¹⁵ We must be willing to do what is necessary to produce effective patient-centered clinicians to improve health outcomes for our patients. **NCMJ**

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