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Medical Education

Notes for the Primary Care Teachers
TEACHING DOCTOR-PATIENT COMMUNICATION IN FAMILY MEDICINE

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ABSTRACT
Doctor-patient communication skills are important in family medicine and can be taught and learned. This paper summarises the salient contents and main methods of the teaching and learning of doctor-patient communication, especially those applicable to the discipline.
Key words: *Doctor-patient communication, family medicine, teaching*
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INTRODUCTION

The importance of effective communication in healthcare has been well established and proven to enhance patient satisfaction, health outcomes, and adherence to treatment.[1] There is growing acceptance of the need to teach and assess communication skills in undergraduate as well as postgraduate medical programmes. However, teaching communication skills is different from teaching other subjects, with its own subject matter, teaching methods and teaching skills required of the teacher.

The intricacies of nature of work of the family medicine discipline can make the tasks of teaching communication skills more complex. Especially in family medicine, communication skills encompasses not only interaction with patients but also information exchange – verbally and written – with their families and other members of the healthcare team.[2]

Family doctors are usually known as well as expected to be good communicators, thus teachers of the discipline need to acquire the knowledge and skill to teach medical communication. This article discusses mainly teaching skills for the teaching of 'doctor-patient communication', that being the main type of communication expected in the discipline.

WHAT TO TEACH?

A sound teaching-learning activity begins with identifying the contents of the training – the 'what'.[1] Each consultation is complex and unique. Thus, having a memorable guide or model of doctor-patient communication to follow can prove easy for learners, so that they can do it 'right'.

A wide range of models has been described and most do fit into the picture of family medicine consultation. These usually encompass a combination of the following:

- Verbal and non-verbal behaviours or communication 'microskills' (for example, eye contact, facial expression, open questions, summarising, empathy, etc), and
- Important tasks or communication elements to cover within a consultation (for example, building of a doctor-patient relationship, explanation & sharing of information, etc.)

The Kalamazoo Consensus Statement[3] is probably a good example of an all-encompassing model of doctor-patient communication for ambulatory care such as family medicine. It outlines seven essential communication tasks that should be part of communication-oriented curricula and evaluation tools:

- Build the doctor-patient relationship
- Open the discussion
- Gather information
- Understand the patient's perspective
- Share information
- Reach an agreement on problems and plans
- Provide closure

Other models include the ILS (Invite-Listen-Summarise), The SEGUE Framework, and the Calgary-Cambridge Observation Guide[2]. All these models promise to be powerful in providing detailed guidance about analysis of consultations. It is advisable that the family medicine teacher

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selects one model, gets familiar with it, practises it before teaching or even later adds to or alters it according to his or her opinion and experiences.

The medical communication models also have been found to help teachers in the planning of teaching sessions. For example, sessions on building rapport and gathering and giving information are the focus in undergraduate teaching, whilst emphasis on 'reaching agreement on problems and plans' or more complicated communication such as dealing with angry or emotional patients would be the focus for postgraduate trainees in family medicine.

DIFFERENT METHODS OF TEACHING COMMUNICATION SKILLS

The principles underlying communication skills teaching should be the same as the principles of teaching other skills in medicine[4] which can be simplified as the following:

- providing knowledge on what to be covered
- demonstrating the skill
- providing sufficient practice
- giving sufficient feedback and reinforcing learning

Popular methods of teaching communication skills are listed below:

- role-modelling
- observation of learners' consultations ('precepting')
- role-play
- videotaping (or audiotaping) learner's consultation
- cinemeducation (learning from movie clips or other pre-recorded materials)
- interview practice with standardised patients

In the context of family medicine discipline, all of the methods, except the last one, can be easily incorporated during clinical teaching; for example during a clinical attachment in a family medicine teacher's clinic. A more formal teaching-learning session may be needed for interview practice with standardised patients.

Whatever method used, the cornerstone of each teaching session is analysis of the interaction, i.e. checking whether skills or tasks described by a chosen model is being covered (quantitative) and if covered, whether the skills are demonstrated competently (qualitative). Normally, communication skills observation tools or checklists are used and these aid both learners and teachers. A convenient example of a communication skills observation tool is the Harvard Medical School Communication Skills Form which is adapted from the Kalamazoo Consensus Statement[2].

TEACHING DOCTOR-PATIENT COMMUNICATION DURING CLINIC ATTACHMENTS: SOME TIPS

Family medicine teachers usually have busy clinics, and for the untrained, grouses of not having time to teach their students or learners are often heard. A few tips on incorporating communication teaching during busy clinics are described as follows:

- Role-modelling: The teacher provides a printed communication observation tool (preferably after a prior introductory lecture or explanation about the observation tool), then asks the learners to observe his or her consultation, mark observed skills and/or make notes. Discussion on strengths and weaknesses can be done after the clinic session or learners can be encouraged to reflect on their observations in a diary or log. Even though learners would not be able to practise the skills, role-modelling can be a quite powerful way to inculcate positive values in learners. However, while most learners may enjoy watching their teachers in action, this method can appear threatening to new teachers of the discipline.
- Observation of learner's consultation ('precepting'): During less busy times, the learner may be allowed to perform the consultation; either the whole consultation or in parts. A common practice is to allow learners to initiate and then gather some information before the teacher takes over the consultation. Learners normally love this 'hands-on' opportunity, despite the fact that they are being watched. Communication observation tools may be used by both the teacher and learner (as self-evaluation). Discussion and feedback, based on the observation, need to follow on as far as possible. Giving feedback has been covered in greater depth in another article in this series and readers may want to refer to this[5].
- Role-play: This simulation technique is widely used normally in formal small group sessions and allows the practise of skills in a safe setting. In a clinic situation, a teacher might grab teaching opportunities – for example after dealing with breaking bad news – by role-playing as the patient and asking the learner to role-play being the doctor and simulate what he or she has observed. This gives opportunities for learners to practise a newly-learned skill and reinforce learning.
- Review of pre-recorded consultations: This methodology certainly needs preparation as well as equipment, but can be very effective in changing behaviour. With the progress of technology, portable video cameras (or at least audiotaping facilities) are easily accessible, and viewing them can be done with any standard office computer. Learners can be asked to videotape their consultations in a different room, and view them together with the teacher later. Further details in handling audio and video recording (such as getting

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consent from the patient) are available[1,2] and can be easily taught to learners.

Note: More information and resources about the topic are available via the author.

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Men with lower testosterone have higher risk of dying

Khaw KT, Dowsett M, Folkerd E, et al. Endogenous testosterone and mortality due to all causes, cardiovascular disease, and cancer in men: European Prospective Investigation Into Cancer in Norfolk (EPIC-Norfolk) Prospective Population Study. *Circulation*. 2007;116(23):2694-701

This is a nested case-control study of 11,606 men aged 40-79 years. Endogenous testosterone concentrations at baseline were inversely related to mortality due to all causes, cardiovascular disease, and cancer (after adjustment for confounders e.g. age, body mass index, systolic blood pressure, blood cholesterol, cigarette smoking, diabetes mellitus, alcohol intake, physical activity, social class, education).

Note: This study does not prove that replacement of low testosterone leads to prolongation of life.