Clinical communication training in continuing medical education: Possible, do-able and done?

Three papers in this month’s Patient Education and Counselling highlight a major concern in clinical communication training, the effectiveness but poor reach of communication training programmes in continuing medical education.

While by no means true in all countries, at its best communication skills teaching has become established as an integral component of medical school curricula with high prominence both in time devoted to education and assessment. Communication has increasingly been integrated within mainstream undergraduate medical education and recognised as a major component of clinical competence that can and should be taught [1]. Contrast this to the state of communication training in continuing medical education. With a few notable exceptions [2–4], it is hard to find either established comprehensive programmes, or training that reaches out to high numbers of potential recipients. These three papers combine to demonstrate the issues involved.

Firstly, Berkhof et al. [5] have undertaken a systematic review of previous systematic reviews/meta-analyses of communication skills training programmes in CME. Their conclusions strongly mirror current perceived wisdom about the primacy of experiential communication training: “training programmes are effective if they are learner-centred, practise-oriented, and have a duration of at least one day. Role-play, feedback and small group discussions are effective training strategies. To maintain skills over time, it is important that physicians continue to practise. We found no evidence for the effectiveness of modelling, written information, or oral presentations alone”. They also say that “if oral presentation is combined with practical rehearsal, it might be effective”. Berkhof et al.’s study design has the self-acknowledged limitation that it is a review of reviews rather than of the original papers, and grades the quality of the reviews rather than the papers themselves. The further away you get from the original source of information, the more difficult it is to see the fine details clearly and come to conclusions about which specific strategies are effective and why.

So far then this is useful confirmation of the evidence base for strategies for experiential communication learning that has been building since Maguire’s pioneering work in the 1980s [6]. In the second paper in this triad, Jensen et al. [7] demonstrate these principles in practice. Using a crossover randomised controlled trial study, they showed that a two day course mixing theory with experiential practice involving participant role-play, feedback and small group discussion improved learners’ communication skills when videoed with real patients in learners’ own practices later. The improvement in communication skills was not associated with any increase in duration of the encounters. What this study adds is the demonstration of this effect in a mixed learning group of senior and junior hospital doctors from a wide range of medical and surgical disciplines, and in encounters that included outpatient contacts, bedside visits on rounds and inpatient encounters as part of diagnostic or therapeutic procedures. Presumably the clinicians involved knew that, in the post-intervention videos, they were being observed to assess whether they demonstrated the specific skills in the Four Habits model which may have influenced the results.

So we know what’s possible and that it is do-able. But is it done? Rotthoff et al. [8] look at the extent of communication skills teaching in CME for all doctors in a German region. They found that 2% of CME events related to the topic communication, with 60% of these involving active participation. However, most of these events were in the fields of psychiatry and psychosomatics while in internal medicine/general medicine/paediatrics only 0.2% of CME events related to communication.

That the provision of communication teaching in CME in Germany is low confirms a widespread anecdotal impression elsewhere. In the United Kingdom, despite highly developed undergraduate medical communication curricula and the presence of summative assessment in communication in most higher medical qualifications, only in senior cancer care specialist training is there comprehensive, compulsory communication training for hospital doctors [2]. Communication training so often disappears into a black hole after doctors qualify, especially in hospital based specialties. Where it does exist, it is ad hoc and patchy in coverage. Communication training is rarely sustained over time, nor supported in the workplace [9]. Without nurturing, improvements from communication training are likely to flounder in the face of the pressures from workload, time issues, inappropriate modelling and apparent lack of valuing of this absolutely central clinical skill. Communication needs integrating into mainstream medical education, rather than being perceived as a highly optional add-on extra [10].

Turning the lessons from research about the effectiveness of communication training in continuing medical education into sustained and comprehensive training in all specialties should become a priority. To achieve this needs political will and financial investment. The reason for the success of the advanced cancer programme in the UK is a combination of high quality research which demonstrates the effectiveness of training, combined with political commitment and financial support at the highest level. Researchers and medical educationalists need to engage with medical politicians if they wish to see their work achieve the widespread results it deserves.
References


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