

Teaching Physicians Communication Skills: Where We Are, How We Got Here

by

Andrew Clarke

M.D., University of British Columbia, 1986
B.S., Stanford University, 1982

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Approval

Name: Andrew Clarke

Degree: Master of Education

Title of Thesis: *Teaching Physicians Communication Skills:
Where We Are, How We Got Here*

Examining Committee: **Chair:** David Kaufman
Professor

David Kaufman
Senior Supervisor
Professor

Michael Ling
Internal Examiner
Senior Lecturer
Faculty of Education

Date Approved: April 24, 2013

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Abstract

At the end of the twentieth century, the medical profession realized that physicians did not have the communication skills they needed in order to serve society in a manner consistent with their individual and collective aspirations. The curriculum of the medical profession was reformed as a result. Positivist biases within the profession influenced this reform, freezing the profession's view of communication skills as simple mnemonic tools rather than profound, lifelong evolutions of worldview. The tool-oriented conception of communication skills contributes to physicians' premature abandonment of the pursuit of expert performance in interpersonal communication.

To reach an expert level of communication competency that aligns with their professional aspirations, physicians may wish to revisit their curricular choices.

Keywords: medical education; communication skills; relationship-centered care; patient-centred care; professionalism

*I dedicate this work to my mother,
Jean Mary Parker Clarke (1919-2012).*

*Jean was a consummate communicator,
and contributing to the health and well-being of the
entire planet was a lifelong priority for her. She used
her words and her music expertly
to spread love and compassion,
with the full understanding that
the more she gave away, the more she had.*

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1. Introduction

In this paper I examine some of the important choices that were made around the turn of the twenty-first century as the interpersonal communication competencies and skills expected of physicians were being incorporated into the official curriculum of the profession. In the following sections I describe how certain political forces within the profession facilitated the assessment of a need for reform, and how the type of reform that was needed subsequently became contested. Subsequently I look at some of the benefits that educators hoped for in reforming the curriculum to include and emphasize interpersonal communication skills, and also whether these benefits have been realized in practice, or remain theoretical. I then present two possible theories about why reforming the medical curriculum to include communication skills may not yet have yielded the intended effects. In doing so, I locate sources of resistance within the informal curriculum of medicine to the types of reform that were undertaken.

2. Physicians' Communication Skills: Evolving Meanings

In this section of the paper, I trace the evolution of the concept of physician communication skills from a narrow definition centring on efficiency and accuracy that was prevalent in the mid twentieth century to a broader definition centred on relationship competencies.

2.1. Physician Communication Skills Prior to 1980: Narrowly Defined

Mid twentieth century discourse about physicians' communication skills tended to focus on the efficiency and accuracy of communication with patients: obtaining the right information from the patient to reach a correct diagnosis, and communicating a diagnosis and treatment plan back to the patient as efficiently and accurately as possible. Even the broader conceptions of communication skills went only as far as the ability to recognize factors that might interfere with either accuracy or efficiency, and to mitigate their influence:

As every beginning medical student learns, history taking is a major diagnostic tool. Such interviewing requires a great deal of skill and understanding, and when there are reasons for reticence and fear, such as in an initial medical visit, even greater demands are placed on the doctor and the patient in their attempt to communicate with one another. (Zola, 1963, p. 829)

In this narrow conception of physician communication skills, there are two principal parts: 1) information *gathering* abilities—asking questions so that all relevant pieces of information are elicited, or putting patients at ease so that important information is not withheld; and 2) information *giving* abilities—writing or speaking in a way that makes ones meaning understood, or explaining diagnoses and treatment plans in “plain

language” that patients understand. Generally these skills were thought to be relevant to physicians almost exclusively in the context of encounters with patients.

Any ability that went beyond the efficient and accurate transmission of facts from sender to receiver was, for the most part, conceived of as a specialized psychiatric or psychotherapeutic skill rather a general competency applicable to all physicians (Balint, 1954). Innovation in the area was directed toward improving efficiency and accuracy of data collection, rather than deepening the relationship between physician and patient:

The traditional dialogue technique used by physicians to obtain a medical history is time-consuming and cumbersome to record. The use of questionnaires and automated devices to perform these functions for the physician is being tested by numerous investigators. These newer techniques have been shown to be superior to the physician's dialogue history in terms of providing a recorded data base of patient information for future retrieval. They also enable easy collection of statistical information about symptomatology in diseases. However, there is no information available as to whether they better enable the physician to make an assessment of the patient's condition with respect to initial diagnostic and therapeutic decisions. Thus, at this time, they cannot be considered as a substitute for the physician-obtained medical history. (Simborg DW, 1969, p. 1443)

2.2. Broadening and Re-centring the Definition: the 1980s

At the start of the 1980s, a number of ideas were circulating that would soon come together to create momentous change in the formal curriculum of medicine. Carl Rogers' practice of client-centered therapy (1961) had been influencing the discourse of therapeutic relationships for 20-30 years. George Engel and others like him were challenging the supremacy of biomedicine by proposing and promoting a more holistic, biopsychosocial model of health and disease (Engel, 1977). And popular retellings of quantum mechanics (Capra, 1975; Zukav, 1979) were helping scientifically oriented physicians become more comfortable with models of reality that blurred the separation between physician-as-knower and patient-as-known.

The 1980s were also a time of major upheaval within the medical profession itself. In Canada, general practitioners were seeking to define themselves positively as an independent speciality called Family Practice, rather than as the absence of any other specialization. McCracken and colleagues proposed and defined “a patient-centred

method of consultation” as a way of forging this positive definition of family practice as a specialty:

There is not yet a family practice model of [the] consultation [between doctor and patient], and the result is wide differences in residency programs' curricula, and residents' perception that their teachers contradict each other. This paper proposes that residents be taught, and practicing family physicians use, a patient-centred method of consultation in which the physician attempts to understand how the patient interprets his illness, as well as to establish the relationship between illness and organic pathology. (McCracken, Stewart, Brown, & McWhinney, 1983, p. 2313)

This model specified a way of relating to patients that was different from what had been practiced previously:

The essence of the patient-centred method is the physician's attempt to understand the meaning of the illness for the patient. Instead of (or as well as) interpreting the illness in terms of his own world, the doctor tries to enter the patient's world. (McCracken et al., 1983, p. 2314)

It also called upon family practitioners to employ a wider range of communication skills than had previously been considered relevant to all physicians:

The crucial skill is the ability to respond to verbal and non-verbal cues which the patient provides. Through careful listening and the use of open-ended questions and facilitating remarks, the patient is encouraged to express his thoughts and feelings. (McCracken et al., 1983, p. 2314)

Furthermore, the patient-centred care model clearly did not limit the use of these skills to cases of psychiatric illness. Instead, it called for their use in *every* encounter with a patient.

There are two ways of thinking about the patient-centred method. One is to think of it as the 'second line', to be called up when the disease-centred method has failed to find an answer to the patient's problem. The other point of view-and the one we ourselves hold-is that the patient-centred method should be used in every case, and the doctor-centred method

used whenever the situation requires it. In our view, it is always important to respond to cues which lead to an understanding of the context of the illness. It is also always important to understand the patient's agenda, his values, priorities and the meaning the illness has for him. (McCracken et al., 1983, p. 2314)

Following the publication of McCracken's article, patient-centred care quickly took the medical profession by storm, establishing itself as an aspirational standard that could scarcely be questioned. Simultaneously, scholars like Thomas Inui (Inui, Carter, Kukull, & Haigh, 1982; Inui & Carter, 1985) and Debra Roter (Roter & Hall, 1987) began to refine systems for the description and analysis of physician-patient encounters in terms of physician communication behaviors. Their work and others' began to elucidate many correlations between a variety of salient outcomes and the communication skills of physicians. I will survey some of this work (and other work that built on it) later in this paper. However, what I wish to point out now is that as physician-patient communication began to be studied in earnest in the 1980s it became clear that most physicians did not possess the skills to achieve the standard of patient-centred care that was then emerging. By the end of the decade, the following consensus about the need for reform had been reached at a conference in Toronto:

Sufficient data have now accumulated to prove that problems in doctor-patient communication are extremely common and adversely affect patient management. It has been repeatedly shown that the clinical skills needed to improve these problems can be taught and that the subsequent benefits to medical practice are demonstrable, feasible on a routine basis, and enduring. There is therefore a clear and urgent need for teaching of these clinical skills to be incorporated into medical school curriculums and continued into postgraduate training and courses in continuing medical education. (Simpson et al., 1991, p. 1387)

This statement (the "Toronto Consensus") was essentially the needs assessment that would drive curricular reform in the ensuing decade.

2.3. The 1990s: Two Roads Diverge

Starting with the consensus about a clear and urgent need for medical curricular reform to address the expanded definition of communication skills, scholarship justifying what kind of reforms to make soon split into two threads. The first, more dominant

thread involved many independent researchers from diverse backgrounds, each of whom focused on either the description and measurement of physician communication behaviors in a particular context, or on the design and testing of interventions to improve these. The second thread took a different approach. The scholars working within it focused on developing a unified theory of practitioner communication that would apply in a variety of contexts including, but not limited to, the physician-patient encounter.

2.3.1. The Many: Development and Testing of Situation-Specific Communication Tools

Throughout the 1990s, scholarly work on physician communication gathered momentum. Some researchers continued earlier work (Levinson & Roter, 1993, 1995; Roter & Hall, 1987; Roter DL, 1997; Suchman, Roter, Green, Lipkin, & The Collaborative Study Group of the American Academy on Physician and Patient, 1993) while others started new projects to develop, refine and test both educational interventions, and systems for analyzing and measuring their effects. Reviews were undertaken to make sense of the data that were emerging. Although the consensus that effective physician-patient communication improved patient health outcomes continued to solidify (Stewart, 1995), confusion remained because of the large number of different assessment instruments that were used in the many contexts where studies were undertaken (Boon & Stewart, 1998). One way of grappling with this uncertainty was proposed by Sanson-Fisher and Cockburn. They proposed that communication skills should not be seen as general or context-independent, but rather highly situation-specific. Their article proposed:

...seven criteria by which to select clinical issues which are appropriate foci for communication skills courses. The criteria are : (1) the issue must be one which is encountered frequently in clinical practice; (2) the issue must be associated with a high burden of illness; (3) there must be evidence that practitioners need to improve skills for dealing with the issue; (4) there must be an intervention, of which communication skills are an integral component, that is demonstrably effective for dealing with the clinical issue; (5) the intervention must represent a cost-effective means of dealing with the issue (6) the intervention must be acceptable to doctors and be able to be incorporated into routine medical practice; (7) the intervention must be acceptable to patients. (Sanson-Fisher & Cockburn, 1997, p. 52)

2.3.2. The Few: Relationship-Centered Care

Meanwhile, other scholars were taking a different approach. In January 1992, the Pew Health Professions Commission and the Fetzer Institute formed a task force to examine ways of developing health professions curricula and practices that promote an integrated approach to healthcare, resulting in the publication of *Health Professions Education and Relationship-Centered Care: Report of the Pew-Fetzer Task Force on Advancing Psychosocial Health Education* (Tresolini & Pew-Fetzer Task Force, 1994). This landmark document extended the patient-centred care model in important ways. Primarily, it encouraged practitioners not only to enter the patient's world (as patient-centred care had done) but to become conscious of their own world through a practice of self-reflection. It also made the point (obvious in retrospect) that patients and physicians do not live in separate worlds, but rather co-inhabit a common one:

A change of paradigm requires that physicians and other health professionals acknowledge and value their capacity to be self-reflective; that is, make explicit their ability to reflect on their own interpretations of the phenomena of illness and the importance of doing so. In this way, they can become more open to different ways of responding to the experience of their patients, especially their sufferings. Healer and sufferer are not separate and independent units. Each is an observer of the other: each interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both healer and sufferer are changed in the process. Healer and sufferer, human and environment, form an inseparable unit of interdependent subjects. The notion of "subjective" and "objective" as different categories of knowledge becomes untenable. 'When the knower participates in the known, all knowledge is personal' (Polanyi, 1958). *The need for the health professions to become more reflective or contemplative disciplines calls, therefore, for a profound change in professional education, from a curriculum dominated by abstractions and intellectual analysis to one balanced between intellectual analysis and the depths of human experience [emphasis in the original].* Moreover, intellectual analysis should be founded on a scientific paradigm that allows irreducible mental events and processes to be taken into account as etiologic factors in health and disease. (Tresolini & Pew-Fetzer Task Force, 1994, p. 22)

Although the primary contribution of the Pew-Fetzer Task Force was certainly their call to make self-reflection the cornerstone of a revised professional curriculum, they also developed other important concepts in the report. For example, they put forward the notion that the patient-practitioner relationship is not the *only* relevant

relationship to consider in the education of health professionals; community-practitioner and practitioner-practitioner relationships are equally important (p. 27). Moreover, in cataloguing the knowledge, skills and values that would guide such a profound curricular transformation, they gave primacy to self-awareness and self-growth objectives as *pre-requisites* to communication competencies directed outward:

...the practitioner must develop knowledge and skills in, and attribute value to, each of the following four areas: (a) self-awareness and continuing self-growth, (b) the patient's experience of health and illness, (c) developing and maintaining relationships with patients, and (d) communicating clearly and effectively. (p. 28)

And so at a critical juncture in the lead up to the reform of the medical curriculum, there were two competing views of the meaning of communication skills for physicians. One view held that communication skills are context-specific tools. In this view, a communication skill is conceived of as if it were a surgical procedure or a drug: proof of its efficacy required for each context where it might be applied. The other view held that communication skills are general, that they proceed out of self-awareness, and that they lead to a continuous deepening of the practitioner's understanding of the varieties of human experience. In the next section of the paper, I will look at the extent to which these two competing models were incorporated into the official curriculum of the medical profession.

2.4. Turn of the 21st Century: Reaching Official Consensus

Although patient-centred care might have had its origins in the struggle of family practice to define itself positively as a discipline, family practitioners were not the only ones examining the role of communication competencies in the medical curriculum. The Royal College of Physicians and Surgeons of Canada (the national organization responsible for setting criteria for the training and certification of medical specialists) also identified a need "to respond not only to the fiscal realities and the information explosion but also to the needs and expectations of society that go beyond physicians' technical knowledge and skills" (Frank & Langer, 2003, p. 972). In the 1990s it undertook a decade-long project to create a core competency framework for Canadian specialist doctors, which eventually adopted the name *Canadian Medical Education Directions for Specialists (CanMEDS)*.

CanMEDS is an educational framework identifying and describing seven roles that lead to optimal health and health care outcomes: medical expert (central role), communicator, collaborator, manager, health advocate, scholar and professional. The overarching goal of CanMEDS is to improve patient care. The model has been adapted around the world in the health profession and other professions. (Royal College of Physicians and Surgeons of Canada, 2013)

Because the CanMEDS framework includes a variety of roles, it is tempting to conclude that the principles of relationship-centered care are embedded within it. However, a closer look reveals that this is not the case. Take for example the key competencies¹ listed under the role of Communicator:

Develop rapport, trust and ethical therapeutic relationships with patients and families;

Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals;

Accurately convey relevant information and explanations to patients and families, colleagues and other professionals;

Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care;

Convey effective oral and written information about a medical encounter. (Royal College of Physicians and Surgeons of Canada, 2005)

While the first competency acknowledges the value of trusting, therapeutic relationships with patients and families, the rest of the list sounds like an echo from the 1960s. Information gathering and dispensing are what is important. Accuracy, efficiency and clarity are the value priorities, rather than the self-awareness, compassion or empathy called for by the Pew-Fetzer Task Force.

Any hope that we might find the transformative views of the Pew-Fetzer Task Force hidden in other places within CanMEDS also quickly dissolves. For example CanMEDS views a Collaborator as someone who can:

¹ Each of these core competencies lists “enabling competencies” which I have omitted for brevity.

Participate effectively and appropriately in an interprofessional healthcare team; [and]

Effectively work with other health professionals to prevent, negotiate, and resolve interprofessional conflict.

Missing from this is any acknowledgement of the complexity of discerning what *effective* and *appropriate* participation in an interprofessional team might look like, except perhaps that conflict will surely be one of the results. Similarly, in their Professional role, physicians are expected to:

Demonstrate a commitment to their patients, profession, and society through ethical practice;

Demonstrate a commitment to their patients, profession, and society through participation in profession-led regulation;

Demonstrate a commitment to physician health and sustainable practice.

The enabling competencies listed for item (3) include:

3.1 Balance personal and professional priorities to ensure personal health and a sustainable practice;

3.2 Strive to heighten personal and professional awareness and insight;

3.3 Recognize other professionals in need and respond appropriately.

While item 3.2 does echo the imperative from the Pew-Fetzer Task Force to develop self-awareness and self-growth, it is positioned in CanMEDS at the bottom of a very long list, rather than as the first and foremost guiding principle.

As work within Canada was focusing on CanMEDS, international efforts were advancing consensus about how to incorporate communication skills into in medical curricula. These efforts culminated in an international conference in Kalamazoo, Michigan in 1999. The proceedings of this conference were condensed into a statement published two years later (Makoul, 2001). The so-called “Kalamazoo Consensus” officially endorses “a patient-centered, or relationship-centered, approach to care, which emphasizes both the patient’s disease and his or her illness experience” (p. 391) and

acknowledges that “building a relationship is an ongoing task within and across encounters [which] undergirds the more sequentially ordered sets of tasks identified below” (p. 391). Although the explicit mention of relationship-centered care is encouraging, the sequentially ordered set of tasks which follows it is not. As I hope to show later in this paper, it has the unintended effect of trivializing a set of lifelong aspirational goals by equating them with simple tasks like measuring blood pressure or heart rate.

The Kalamazoo Consensus and the CanMEDS Framework taken together became, more or less, the official version of how communication skills should be incorporated in to the professional curriculum of medicine. And while each nods somewhat approvingly in the direction of relationship-centered care, neither of them signals “a profound change in professional education, from a curriculum dominated by abstractions and intellectual analysis to one balanced between intellectual analysis and the depths of human experience” (Tresolini & Pew-Fetzer Task Force, 1994, p. 22). Instead, both documents chose (perhaps unconsciously) to adopt the stance of Sanson-Fisher and Cockburn: that communication skills are context-specific and outward looking tools; and that they can be captured in task-oriented checklists and other instrumental embodiments. In the sections that follow, I will discuss some of the potential effects of this choice, and finally some potential reasons why the choice might have been made this way.

3. Effects of curricular revision

In this section I will briefly review some of the literature that inspired the revision of the formal curriculum of medicine to include communication competencies. Where possible I will include evidence of whether the revision of the curriculum has either had its intended effect or not.

3.1. Patient Satisfaction

Increasing the satisfaction (or reducing the dissatisfaction) of patients and their families was perhaps the earliest reason to focus on enhancing physician communication skills as they came to be seen in the 1980s and 1990s (Korsch, Gozzi, & Francis, 1968). Empirical evidence of the correlation between higher levels of physician communication skills and higher levels of patient satisfaction emerged early (Buller & Buller, 1987) and was confirmed consistently by studies in which audiotaped physician-patient interactions were analyzed and correlated with patient survey data (Brown, Boles, Mullooly, & Levinson, 1999; Williams, Weinman, & Dale, 1998). These studies confirmed what communication skills education for physicians *can* do.

However, there are very few studies that show what communication skills education for physicians *does* do. Answering this research question is difficult, and studies that can effectively address it are rare. Fortunately, there are at least two studies (or data sources) that together allow indirect inference about broad trends in patient satisfaction and their correlation with physician communication skills. Tamblyn and colleagues (2007) followed 3424 physicians who took the licensing examination of the Medical Council of Canada between 1993 and 1996, and who obtained licenses in Ontario and Quebec from 1996 until 2005. They tracked all complaints made to licensing authorities against these physicians in these two jurisdictions. Of the 1116 complaints made, physician communication style or effectiveness was a principal factor in 999 (~90%). Furthermore, a low score on the communication component of the licensing examination was significantly correlated with the tendency to receive a

complaint during the follow-up period. While this study does confirm that complaints to licensing authorities are a good proxy measure for the communication competency of a population of physicians, it says nothing about the success of the early twenty-first century curriculum reforms. This is because the study population would not have been exposed to the new curriculum, given that it was fully implemented only in 2003 (Frank & Langer, 2003).

Another source of data fills the gap, however. The Canadian Medical Protective Association (CMPA) has been in existence for over 100 years offering advice and legal counsel to 83,000 Canadian physicians as a mutual defense association. Although technically not a provider of malpractice insurance *per se*, it functions as such in every relevant way. In its annual report, it publishes statistics about the complaints brought against its members. The most recent data available on the CMPA website show that between 2007 and 2011, rates of complaint brought against physicians to provincial licensing authorities increased at an average year-over-year rate of 7.4%, while rates of complaint to hospitals increased at an average rate of 3.5% (Canadian Medical Protective Association, 2011).

As with most important matters of educational policy in the public sphere, firm conclusions are difficult to draw. However, there does not appear to be any indication that rates of patient complaint are declining. In fact they continue to rise substantially, and are known to be almost entirely related to physician communication styles and practices. And while the effects of curricular change can be expected to take many years to be visible at Kirkpatrick's (1996) fourth level of evaluation, it remains disappointing that there is not yet any empirical reassurance that patient satisfaction is improving since the revision of the medical curriculum a decade ago.

3.2. Patient Health & Safety

Reforming the medical curriculum to emphasize physician communication skills was expected to yield not only subjective improvements in patient satisfaction, but also objective improvements in patient health and safety. This was, in fact, the explicit overarching justification of the CanMEDS project. Improvements in patient health and safety take two related but distinct forms: more intense success, and less frequent failure. Substantial empirical evidence supports the correlation of physician

communication skills with both of these outcomes. When physicians communicate poorly, errors result and patient outcomes are not as intended (Dayton & Henriksen, 2007). This effect is observed both when the primary focus is on physicians' relationship skills (Barton & Sutcliffe, 2009; Sutcliffe, Obstfeld, & Weick, 1999; Weick & Sutcliffe, 2003) and when it is on more technical communication skills, such as the use of procedural checklists (Gawande, 2009; Haynes et al., 2009). On the other hand when physicians communicate well, the health outcomes of their patients are better in ways that are both clinically and economically relevant. Patients are more likely to follow difficult treatment plans (Haskard-Zolnierrek & DiMatteo, 2009), and to take personal responsibility for managing their chronic diseases, resulting in healthier patients and lower system costs (Heisler, Bouknight, Hayward, Smith, & Kerr, 2002; Trummer, Mueller, Nowak, Stidl, & Pelikan, 2006).

However, trying to determine whether reforming the medical curriculum in the area of communication skills *is* actually making a meaningful difference to patient health and safety is virtually impossible. Since the publication in 2000 of a landmark report by the Institute of Medicine in the United States (Kohn, Corrigan, & Donaldson, 2000), interest in improving the quality and safety of patient care in developed countries has exploded. There are so many simultaneous initiatives taking place in so many areas, that it is becoming increasingly difficult to attribute any large-scale effects to one particular influence. However, those at the centre of important national efforts to improve the quality and safety of care seem to acknowledge the important role played by physicians' interpersonal communication practices, and the culture that both creates them and is created by them:

The combination of complexity, professional fragmentation, and a tradition of individualism, enhanced by a well-entrenched hierarchical authority structure and diffuse accountability, forms a daunting barrier to creating the habits and beliefs of common purpose, teamwork, and individual accountability for successful interdependence that a safe culture requires. (Leape & Berwick, 2005, p. 2387)

Although the medical profession had hoped that incorporating communication skills into formal curricula and examination standards would improve health and satisfaction for patients, it seems that these hopes have not *yet* been realized. It may be

true that the right wheels have been set into motion, and that more time is needed to reach the intended destination. However, it may also be the case that the “daunting barrier” Leape and Berwick refer to may be insurmountable with the current curriculum.

4. Informal Curricular Influences

In this final section, I look at two factors within the informal (hidden) curriculum of medicine that may restrain physicians' learning of communication skills. Each of these factors may also have influenced the choice made during the curriculum reform in the 1990s when medicine turned away from profound change and toward a more tool-oriented representation of physician communication skills. Many factors influencing this choice are explained within the Pew-Fetzer Task Force report itself; I will not repeat these. Instead, I will focus on ideas that I hope will make a positive contribution to the discourse on the topic. The first idea concerns the unconscious conception within medicine of qualities such as empathy, care and compassion as rival² rather than non-rival goods. The second involves connecting the choices made about the medical communication curriculum to theories of mindfulness, and expert performance.

4.1. Discourses of empathy, care and compassion in medicine and related fields

When qualities such as empathy, care and compassion are discussed in medicine, much effort is expended defining them or differentiating them from other similar ideas. As with many socially constructed entities, their meaning is still contested in medical discourse: there is no clear and prevailing viewpoint about what they are, or how their presence is determined and characterized (Salmon & Young, 2005). This contrasts markedly to the agreement that *does* exist, for example, about the presence or relevance of various cells and molecules. When writing about these abstract values,

² I am using the term *rival* here in the sense it is used in economics. A rival (subtractable) good is a good whose consumption by one consumer prevents simultaneous consumption by other consumers. In contrast, non-rival goods may be consumed by one consumer without preventing simultaneous consumption by others. Non-rival goods are usually intangible. When someone turns on a TV in one house, this does not prevent the TV in another person's house from working. The television itself is a rival good, but the information contained in the programming is a non-rival good ("Rivalry (economics)," 2013).

many authors begin by contrasting empathy with sympathy (Darwall, 1998). Some then go on to demonstrate how certain operationally defined constructs such as perspective-taking (Batson, Early, & Salvarani, 1997) and emotional intelligence (Salovey & Mayer, 1990) fail to capture the essence of the medical ideal. Others take a turn towards etymology (Rosenberg & Towers, 1986). All definitions seem to arrive eventually at a description of transitive intersubjectivity involving at least one person, usually the doctor, who gives awareness (in the form of care, empathy or compassion) and at least one other, usually the patient, who receives it. Differences arise as to whether various authors call the intersubjective experience cognitive or emotional, and as to how the attention of the giver is oriented: either toward the receiver or toward the receiver's focus of attention. None of this is problematic except in that it unintentionally portrays empathy, compassion, and care as *rival* (scarce) rather than *non-rival* (abundant). For example, consider this statement from Charles Figley:

There is a cost to caring for those with chronic illness just as there is a realization that these clients will never fully recover. As psychotherapists, we learn to be on the one hand objective and analytical in our professional role as helper. We must put our personal feelings aside and objectively evaluate our clients and administer the best treatments according to best practice guidelines. But on the other hand we cannot avoid our compassion and empathy. They provide the tools required in the art of human service. To see the world as our clients see it enable [sic] us to calibrate our services to fit them and to adjust our services to fit how they are responding. (Figley, 2002, p. 1433)

Although Figley is writing about psychotherapists rather than physicians, his statements could just as easily apply to doctors. Figley goes on to explain the concept of *compassion fatigue*:

The very act of being compassionate and empathic extracts a cost under most circumstances. In our effort to view the world from the perspective of the suffering we suffer. The meaning of compassion is to bear suffering. Compassion fatigue, like any other kind of fatigue, reduces our capacity or our interest in bearing the suffering of others. (Figley, 2002, p. 1434)

In Figley's view, empathy and compassion are forms of "emotional energy" (p. 1436): you can either use them to take care of yourself, or use them in service of your patients, but not both. This kind of rhetoric has a great deal of resonance with physicians who

might model their unconscious notion of empathy on glycogen stores, and compassionate endurance on physical endurance.

If empathy, care and compassion are *rival*, physicians will almost certainly be reluctant to direct their use toward themselves, because to do so would deprive a patient of their simultaneous enjoyment. This in turn would directly contradict the first principle of medical ethics which is to “consider first the well-being of the patient” (Canadian Medical Association, 2004).

This line of reasoning affects even the most sophisticated, thoughtful and highly regarded writing about care, compassion and empathy in medicine. Take, for example, the psychiatrist and philosopher Jodi Halpern who has written extensively about the use of empathy in clinical practice (Halpern, 2011). She makes a strong case for empathy to be considered a state of emotional attunement rather than solely a cognitive representation of the mental state of another person. In doing so, however, not once does she examine the possibility that empathy could be offered to oneself, and that to do so might actually facilitate, rather than inhibit, the offering of empathy to another. Here is a representative sample:

There is a long-standing tension in the physician’s role. On the one hand, doctors strive for detachment to reliably care for all patients regardless of their personal feelings. Yet patients want genuine empathy from doctors, and doctors want to provide it. Medical educators and professional bodies increasingly recognize the importance of empathy, but they define empathy in a special way to be consistent with the overarching norm of detachment. Outside the field of medicine, empathy is an essentially affective mode of understanding. Empathy involves being moved by another’s experiences. In contrast, a leading group from the Society for General Internal Medicine defines empathy as the act of correctly acknowledging the emotional state of another without experiencing that state oneself. It goes without saying that physicians cannot fully experience the suffering of each patient. However, the point of saying that the physician does not experience that state oneself is, presumably, to emphasize that empathy is an intellectual rather than emotional form of knowing. This assumes that experiencing emotion is unimportant for understanding what a patient is feeling. (Halpern, 2003, p. 670)

Halpern observes that the valuing of detachment produces a particular stance toward empathy. I argue that the reverse could equally be true: a particular stance toward

empathy (as rival) produces the valuing of detachment. Detachment could be an effective strategy to resolve the dilemma of having to care simultaneously for self and other. If empathy were not unconsciously thought of as *rival*, doctors might no longer *need* to be so detached.

Another way to resolve this dilemma is to invent a new term that is just like empathy, but includes not only the other, but also the self as a receiver of awareness. This is what Peter Fonagy, Jon Allen and their colleagues at the Menninger Clinic have done in coining the term *Mentalizing*. In its simplest definition, mentalizing is the “idea of attending to states of mind in oneself and others” (Allen, 2006, p. 3). More completely,

Mentalizing pertains to a vast array of mental states: desires, needs, feelings, thoughts, beliefs, reasons, hallucinations, and dreams, to name just a few. Mentalizing pertains to such states not only in oneself but also in other persons – as well as nonhuman animals, for that matter. And, as a mental activity, mentalizing includes a wide range of cognitive operations pertaining to mental states, including attending, perceiving, recognizing, describing, interpreting, inferring, imagining, simulating, remembering, reflecting, and anticipating. (Allen, 2006, p. 6)

In comparing mentalizing to empathy, Allen says, “Although empathy is but one facet of mentalizing, it might be the most important. Sometimes when attempting quickly to convey the gist of mentalizing, I point out that if we extended the concept of empathy to include empathy for oneself, the terms would be nearly synonymous” (Allen, 2006, p. 13).

Because mentalizing is a new term, Allen & Fonagy can construct a precise definition to suit their purpose. This is not possible with terms like empathy and compassion that have well understood meanings. But using a new term also leaves behind the positive aspirational associations that the familiar terms carry. Physicians and trainees would mostly agree that they want to empathize or to show compassion, whereas inspiring them to learn mentalizing might require some persuasion. In the end, it seems better to continue with the familiar, but to add footnotes that define empathy and compassion specifically as non-rival. This might then remove the false choice between self-empathy and other empathy, and allow medical educators instead to position self-empathy as a pre-requisite to other-empathy.

4.2. Medical Communication Curricula Predispose to Mindless Overlearning

As previously noted, rates of complaint against Canadian physicians continue to rise, and are more likely to be made against physicians who score poorly on the communication component of their licensing exam. In this section, I will trace a possible explanation for this phenomenon back to potential roots in the choice to represent communication skills in the medical curriculum as simple tools rather than as profound shifts in worldview. I argue that because of the highly charged circumstances in which physicians conduct much of their interpersonal communication, they must acquire expert, rather than basic, communication skills in order to satisfy those around them (including, but not limited to, their patients). If the medical curriculum is to support them in this learning, it must not only provide them with many hours of deliberate practice, but also must motivate them to engage in such practice. The current curriculum fails them in this regard, because it unconsciously represents interpersonal communication as easy, or at least as much easier than performing surgery or treating diabetes and heart failure. It represents communication skills this way because of the way that communication is unconsciously and unintentionally trivialized in documents like the Kalamazoo Consensus and the CanMEDS framework.

Ericsson (2004) proposes a framework “to account for individual differences in attained professional development... based on the assumption that acquisition of expert performance requires engagement in deliberate practice and that continued deliberate practice is necessary for maintenance of many types of professional performance” (p. S70). His work is based on the interpretation of a large body of empirical evidence from a variety of domains of expertise. From this work, he concludes that:

The goal for everyday activities is to reach as rapidly as possible a satisfactory level that is stable and “autonomous.” After individuals pass through the “cognitive” and “associative” phases, they can generate their performance virtually automatically with a minimal amount of effort. In contrast, expert performers counteract automaticity by developing

increasingly complex mental representations to attain higher levels of control of their performance and will therefore remain within the “cognitive” and “associative” phases. Some experts will, at some point in their career, give up their commitment to seeking excellence and thus terminate regular engagement in deliberate practice to further improve performance, which results in premature automation of their performance. (Ericsson, 2004, p. S73)

As they acquire the communication skills that are specified by the current medical curriculum, the majority of physicians pass quickly through Ericsson’s cognitive and associative phases. They reach a level of performance that is stable and autonomous, and can generate the performance they need with a minimum effort. The level of skill they acquire is satisfactory for the majority of professional interpersonal communication contexts in which they find themselves. However, virtually all of them will encounter many situations during their professional careers where their communication competence is strained. This will often occur in a situation of high stress, where outcomes are likely to be poor, and where the risk that others will experience dissatisfaction is already high.

Ellen Langer uses the term “mindlessness” to describe the automatic performance of a task that becomes simple through what she calls “overlearning” (Langer & Imber, 1979). She says:

When an individual first approaches a task she/he is necessarily attentive to the particulars of the task. With each repetition of the task, less and less attention to those particulars is required for successful completion of that task. As “mindlessness” is achieved, the components of the task may drop out or coalesce to form a whole. Learning, then, in a sense is learning what elements of the task may be ignored. Repeated practice with the task as a whole rather than with the individual parts may lead to a strange turn of events. The person who has overlearned the task, the expert, may be in a position of knowing that he/she can perform the task, without any longer knowing how he or she performs it, that is, without knowing the steps or components that make up the performance. If external factors like labels then led the individual to question his or her competence on these overlearned tasks, the individual would have difficulty supplying information about the solution process as evidence of competence and could erroneously infer incompetence. (Langer & Imber, 1979, p. 2015)

Langer's "strange turn of events" is exactly what happens to many physicians. They may feel confident that they can perform such tasks as establishing rapport, demonstrating empathy, or eliciting information. But because they have "overlearned" (to use Langer's term) these skills, they no longer know *how* they do them. When they use their mindless (again Langer's term) patterns of behavior and achieve unintended results, they often find themselves being labeled in some way. While Langer used labels like "assistant" and "boss" in her experiments, those who are dissatisfied with physicians' communication tend to use labels like "disruptive", "inappropriate", "narcissist", and many others that are much more colourful.

A small number of physicians unconsciously counteract automaticity by seeking and producing increasingly complex mental representations of their interpersonal communication contexts. Allen might say that they somehow learn to value mentalizing, and as a result they learn to mentalize. Langer might say that they remain *mindful* (rather than mindless) in their communication practices.

Because it is only a minority of physicians who transcend automaticity to incorporate mindfulness and mentalizing in their interpersonal communication, it is essential to examine to the curriculum itself as a potential cause. One need only contrast the preparation for learning biological procedures with the lack of preparation for learning communication skills to see where unconscious resistance might arise.

Doctors are not taught communication skills in the same way that they're taught biological procedural skills. Before learning how to do venipuncture, for example, they thoroughly study the anatomy and physiology of the skin, veins, red blood cells, etc. They have already looked at the relevant tissues under several different types of microscopes, and learned much about the theory of cells (which is so well tested empirically as to have lost its appearance as a theory). They may not bring much of this knowledge consciously to bear on the situation when they perform their first insertion of an intravenous catheter, but they know that they are working with a collection of tissues and physiologic systems about which much is already known, and they are familiar with the sources of that knowledge. When their results differ from expectations, they therefore know how to adjust their performance to improve it on subsequent attempts. This cycle of checking unexpected results against a deep background of empirical

evidence maintains them in what Ericsson would call the cognitive and associative phases of expert learning.

In contrast, when doctors learn about communication, they are presented with a variety of task-oriented checklists and consensus statements, each one suitable for a particular context (Baile et al., 2000; Lieberman & Stuart, 1999). For example, here are two tools taken from an article whose purpose is “to define the skills underlying the...competencies for communicating with patients” (Gordon, 2002, p. 21):

Eliciting the Patient’s Perspective (FIFE)

F=Function (“How does this affect what you can do and not do?”)

I =Ideas (“What do you think is wrong?”)

F=Feelings (“How are you holding up despite this?”)

E=Expectations (“What were you hoping I would do to help?”)

Components of the Empathy Statement (NURS)

N=Name the feeling (“You look [angry, frightened, sad, worried]”)

U=Understand the feeling (“It’s understandable you’d feel that way.”)

R=Respect the patient’s attempts to cope (“You’re doing the right thing...”)

S=Support and partner with the patient (“I’ll make sure there’s no...cancer”)
(Gordon, 2002, p. 23)

These mnemonically anchored checklists of instructions are quite simple to carry out. They are immediately useful, and contain nuggets of truth and insight that are profound. But none is accompanied by, or built upon references to the theories or empirical observations that underlie it. Many such tools, in fact, have no theoretical or empirical basis (Cegala & Broz, 2002). Medical educators have fallen into the habit of presenting complex psychosocial models as convenient and efficient checklists. This habit has some unintended consequences. For learners, it sends the hidden message that “this is obvious, you can do it easily.” Some authors even acknowledge how this can impede learning:

[Trainees] enter communication skills training with habits and styles developed over decades of communicating with others. As a result, the concepts may seem self-evident and simplistic and the skills unnatural and forced. (Gordon, 2002, pp. 25–26)

Perhaps more importantly, when communication doesn’t go as planned—a patient is not forthcoming about crucial details, or a colleague refuses to provide assistance during a critical procedure—doctors who have not reached expert competence as communicators

cannot fall back on a deeper level of understanding to inquire about *why* the checklist they applied didn't work as expected. As Korzybski might have said, they have mistaken the map for the territory.

Finally, the high level of context specificity of many of these checklists means that each one will be practiced less than if one set of overarching principles were applied in all contexts. Because of this, it would take a physician many more years to accumulate the hours of deliberate practice necessary to achieve Ericsson's expert level, if they were interested in doing so. It would seem preferable to equip physicians with a set of psychosocial skills that are applicable in many contexts, and which they would most likely have the opportunity to practice deliberately for many hours while in training (Martin, 1990).

5. Conclusion

The curriculum of medicine was reformed around the turn of the twenty-first century to respond to the observation that physicians were not being taught the communication skills that society wanted them to have. Although it may be too early to discern the success or failure of the changes already made, there is at least some evidence that physicians are still not able to demonstrate these skills at the expert level that society would prefer. It is possible that certain positivist biases within the professional culture of medicine influenced choices that were made when the curriculum was revised, resulting in the representation of communication skills as simple tools rather than profound and lifelong evolutions of worldview. The tool-oriented conception of communication skills may have contributed to physicians' abandoning prematurely the pursuit of expert performance in interpersonal communication.

To reach the expert level of communication competency that society appears to want from them, physicians may wish to revisit the curricular choices they made previously, and to adopt instead a view of communication skills that aligns more closely with the relationship-centered care model as proposed in the *Report of the Pew-Fetzer Task Force on Advancing Psychosocial Health Education*.

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