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Discussion

Consensus statement on an updated core communication curriculum for UK undergraduate medical education

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ABSTRACT

Objectives: Clinical communication is a core component of undergraduate medical training. A consensus statement on the essential elements of the communication curriculum was co-produced in 2008 by the communication leads of UK medical schools. This paper discusses the relational, contextual and technological changes which have affected clinical communication since then and presents an updated curriculum for communication in undergraduate medicine.
Method: The consensus was developed through an iterative consultation process with the communication leads who represent their medical schools on the UK Council of Clinical Communication in Undergraduate Medical Education.
Results: The updated curriculum defines the underpinning values, core components and skills required within the context of contemporary medical care. It incorporates the evolving relational issues associated with the more prominent role of the patient in the consultation, reflected through legal precedent and changing societal expectations. The impact on clinical communication of the increased focus on patient safety, the professional duty of candour and digital medicine are discussed.
Conclusion: Changes in the way medicine is practised should lead rapidly to adjustments to the content of curricula.
Practice implications: The updated curriculum provides a model of best practice to help medical schools develop their teaching and argue for resources.

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1. Introduction

Clinical communication was introduced into the undergraduate medical curriculum in the 1990s and has become a standard component in all medical courses in the UK, and increasingly, across the world. In 2008 a consensus statement, reached by an iterative consultative process involving representation from all 33 UK medical schools, crystallised the core curriculum for clinical communication for undergraduate medical education [1]. Its purpose was to help teachers to develop their curricula and to have a model of best practice with which to prepare their students for conducting effective, professional and sensitive conversations with patients, relatives and colleagues.

It may seem unlikely that communication teaching should change; unlike our colleagues at the cutting edge of genetic science, we may feel we are dealing with eternal verities about human interactions which surely cannot vary much in a decade. However medical care does change, expectations of medical care alter and doctors' communication must inevitably follow suit. Curricula within medical education must consequently adapt to ensure that students are well prepared for their future practice [2,3].

The drivers of change affecting the clinical communication curriculum can be categorised as:

- Relational
- Contextual
- Technological

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Some relate to new emphases and some to entirely new areas of teaching and learning.

The relationship between the doctor and patient has always been a focus of clinical communication teaching, with an emphasis on patient-centred care and supporting patient autonomy. The concept of shared decision making, which has been elaborated in an extensive literature since the last consensus statement, was recently brought to the fore by a legal precedent arising from a Supreme Court ruling. This concerned the information given to a pregnant patient with diabetes about birth options and their likely benefits and risks [4]. As a consequence of the ruling, which was decided in favour of the patient, consent is now judged on the basis of what a *reasonable patient wants to know*, not what a *reasonable doctor wants to say* [5]. This has overturned long-held beliefs about which member of the doctor-patient dyad is the final arbiter of whether communication has been effective.

The doctor's role reflects societal expectations of those with the skills and knowledge to provide medical care and thus is constantly evolving [6]. The previously radical idea that the doctor and the patient are *both experts in their own areas of experience* [7] has paved the way for an understanding that healthcare decisions are best made collaboratively with the people who have to live with the consequences of those decisions. This was reflected in the UK Government's White Paper in 2010, which emphasised that shared decision making would become the norm in medical care and that patients could expect *'no decision about me without me'* [8]. The notion that the doctor's role is to support the patient in developing an *informed preference* on which to base their decision [9] is gradually replacing the convention that the doctor provides advice with which patient is simply expected to 'comply'. The central role of patients in making decisions about their own healthcare continues to be emphasised in UK national guidance [10] albeit sometimes as a consequence of litigation [11]. An awareness of how the doctor-patient relationship continues to change over time is essential to help students navigate the landscape within which they will practise throughout their careers.

Whilst *patient-centred care* is the philosophy underpinning medical practice in the UK, in reality students are exposed to a variety of models of the doctor-patient relationship. These vary in the extent to which the patient's perspective, autonomy, emotions and individual circumstances are taken into account. This variety of approaches often reflects generational and cultural differences in how students' supervisors were taught, and does not necessarily reflect the standards upon which current graduates will be judged. In order to learn effective approaches to communicating with and supporting patients, students need role-modelling by clinicians which reflects modern standards of care, as well as classroom-based teaching and practice.

Table 1
What patients want from communication with their doctor [18].

- Greeted me in a way that makes me feel comfortable
- Treated me with respect
- Showed interest in my ideas about my health
- Understood my main health concerns
- Paid attention to me (looked at me, listened carefully)
- Let me talk without interruptions
- Gave me as much information as I want
- Talked in terms I could understand
- Checked to be sure I understood everything
- Encouraged me to ask questions
- Involved me in decisions as much as I want
- Discussed next steps, including any follow-up plans
- Showed care and concern
- Spent the right amount of time with me

Even within the last decade, the language used to describe the doctor-patient relationship has changed. Many publications no longer use the word 'patient' when describing a person who uses healthcare services or lives with a long-term medical condition [12–14]. Just as the term 'patient-centred' is becoming more widely understood, it is giving way to the term 'person-centred'. Medical teachers no longer recommend strategies for students to 'deal with emotional patients' or suggest 'allowing the patient to talk' but will refer to 'responding to the patient's emotions' or 'enabling the patient's contribution'. Similarly the labelling of patients (e.g. as 'difficult' or 'heartsink') is rightly viewed as disrespectful and fails to encourage doctors to take responsibility for communicating effectively in situations they find challenging. The use of language demonstrates the expectation that people receiving healthcare are treated with respect and as people rather than as 'diseased bodies' or a source of problems. This challenges the appropriateness of the traditional discourse of a 'passive patient', which is represented by terms still commonly used, such as *'taking a history'*, *'consenting a patient'* and *'compliance with treatment'*.

Despite widespread teaching of the core elements of effective communication, reports continue to appear where doctors:

- fail to introduce themselves or to look at the patient when delivering bad news [15]
- talk about patients as if they were not there [16]
- communicate poorly and show lack of respect [17].

Whilst the causes of these problems are likely to be many and varied, the underlying discrepancy between what people *expect* from medical care and what they *receive* points to a need for healthcare professionals to take communication as seriously as patients do. Any communication curriculum must take into account what patients want (Table 1) [18]. This is becoming an increasing focus of research, with studies noting the importance patients place on the relationship with the doctor, and specifically the doctor's ability to listen, empathise and provide care tailored to the individual [19].

Since the consensus statement was published in 2008, the role of professionalism has been highlighted by a public inquiry in the UK, which emphasised the need to improve standards of care, enhance interprofessional communication and learn lessons from corporate and individual mistakes [20]. This also prompted an increased focus on responding effectively to patients and families affected by medical error, resulting in a new *statutory duty of candour* [21]. The concept of professional behaviour as a taught subject is being increasingly adopted in medical education, incorporating elements of interpersonal skills, working group norms and organisational culture [22]. Lessons learned from analysing adverse events have given considerable impetus to the issue of patient safety. Subsequent directives have been published by national and international bodies providing guidance to professionals who need to raise concerns about patient care [23,24].

In parallel, there has been an increased focus on the explicit teaching of clinical reasoning in addition to clinical communication in some medical schools [25–27]. Inadequate gathering and processing of information have been found to be responsible for

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