The Importance of Physician Communication Skills

Areas in which physicians may benefit from further training in communication skills were suggested by a survey at the Clinical Research Center at Dalhousie University. Moving from a physician-centered to a more patient-centered perspective is one of these items, as is providing more information to patients about their presenting medical complaint and actively involving them in plans for treatment. In addition, the authors believe their survey results support the value of involving patients in a needs assessment of patient-doctor communication in order to identify future needs in continuing medical education.

The survey employed the Calgary-Cambridge Observation Guide as a structural framework for the medical interview. This guide is patient-centered and is a collaborative approach to the medical interview, divided into five tasks:

- **Initiating the session** - including establishing initial rapport and identifying the reason(s) for the consultation.
- **Gathering information** - including exploration of problems, understanding the patient’s perspective, and providing structure to the consultation.
- **Building the relationship** - including developing rapport and involving the patient.
- **Explanation and planning** - including providing the correct amount and type of information, aiding accurate recall and understanding, achieving a shared understanding that incorporates the patient’s perspective, and planning that involves shared decision making.
- **Closing the session**.

Teaching Prevention in the Office

Preceptors are frequently not told what to teach students in their offices and are not provided with the skills to accomplish such teaching. This includes training in the area of preventive medicine. Furthermore, providing preventive health care takes additional valuable time.

In addition, preceptors often do not have the knowledge, skills, and attitudes to provide primary preventive health care so they were unable to teach others. Like their academic colleagues, community physicians are also pressed for time. However, community-based physician offices are an ideal location to teach students about preventive medicine that is an integral part of medical practice. These environments are often superior to traditional hospital clinics and to hospitals where the pace is too hectic to make prevention a high priority. Preventive medicine may be time-consuming for preceptors but is necessary for patients and provides medical students with an appropriate and important educational experience.

(Alguire PC. "Teaching prevention in the office." CBT News. October 2001.)

Multisite Variability in Standardized Patient Scores

Limitations of standardized patient (SP) examinations include decreased reliability of examinee scores attributable to the limited number of cases seen by the student and variations in SP recording, rating, and portrayal of accuracy. It is critical that scores accurately reflect the appropriate clinical skill levels of the examinee.

Reliability may diminish when exams are administered on a large scale and it is necessary to train multiple SP’s to portray the same case across multiple testing sites. Interpersonal skills appear to be more influenced by variation among SP’s than checklist scores. Videotaped encounters that establish base lines of interpersonal skill levels may be more effective.

Inter-site variability in checklist scores may result from differences in training across sites or because guidelines to scoring checklists were not clear (i.e. what student must do to receive credit for completing a given behavior). Some have found little or no difference in scores of candidates taking the same test administered at different sites. Others have found that the site at which the exam is administered can influence candidates’ scores.

(Floreck LM and DeChamplain AE. "Assessing sources of score variability in a multisite medical performance assessment: An application of hierarchical linear modeling." Academic Medicine. 76: S93-S95; Supplement, October 2001.)

Trends in Graduate Medical Education

An American Medical Association (AMA) survey observed that similar to 1999-2000, there has been an increase in the number of subspecialty programs by 2.1 percent (79 more programs) and a decrease in the number of specialty programs by 0.9 percent, or 40 fewer.

Since 1996-1997 there has been a 20 percent decrease in the number of medical school graduates who were matched into primary care residencies, especially family medicine.

Osteopathic medical school graduates training in allopathic medical programs continued to rise, increasing by 7.9 percent since last year. The survey also noted a slight decrease in the number of on-duty hours for first-year residents from 55 to 54 between 1996-1997 and 2000-2001.

Critique of U.S. News & World Report Medical School Ratings

Consumers rely on the reports that are provided annually by U.S. News & World Report concerning the ratings of medical schools. Northwestern University Medical School professors critically reviewed the assessments and comparisons of U.S. medical schools, raising doubts about their problems, weaknesses, and utility. The authors point out five reasons to criticize the U.S. News & World Report ranking.

They include narrow focus, inadequacy of response rate, measurement error, unchanging stability of results, and confounding. Response rates, for example, are mostly under 50 percent, which are not considered to be reliable. They point out that nonresponse error is the single biggest impediment in any survey. In addition, they believe that the annual U.S. News ranking of American medical schools fails to meet the standards of journalistic ethics. The publication provides no evidence that research quality standards have been met or that peer review of the data, methods, or reporting have been sought.

In the opinion of the authors, the annual U.S. News & World Report rankings of U.S. medical schools are ill-conceived, unscientific, conducted poorly, ignore the value of school accreditation, judge medical school quality from a narrow, elitist perspective, do not consider social and professional outcomes in program quality calculations, and fail to meet basic standards of journalistic ethics.


Is it Time to Reform Graduate Medical Education?

While 58 percent of all U.S. medical schools are now involved in significant curriculum reform, except for extensive proliferation of subspecialties and longer training periods, there have been very few modifications in graduate medical education. This is not a sufficient response to the needs of society or for new physicians. Because the actual structure of GME has changed little in the past 50 years, the time has come to tailor trainee experiences to the demands of their future practice.

The author suggests the training of a “generalist specialist.” He defines this physician as one who trains and practices (or intends to practice) as a subspecialist, but who actually broadens that practice to include more general medicine or surgery. In otolaryngology, for example, a head-and-neck surgeon with subspecialty training in neuro-otology could broaden his or her practice to include more general otolaryngological surgery. The author also believes that training programs should be based on achievement milestones rather than on time served.

Johns Hopkins University Department of Neurosurgery has gone through such changes in its residency program so that it was reduced by an average of six to nine months. Their experiment strongly suggested that a competency-based curriculum could be a firmer foundation to achieve and measure skills.

(Is Johns, MME. “The time has come to reform graduate medical education.” JAMA. 286: No. 9; September 5, 2001.)
Computer-based Testing Using High Fidelity Patient Video Vignettes

Paper-and-pencil examinations have their limitations in evaluating the performance of medical students on medical licensing examinations. Computer-based testing provides a vehicle for evaluation of skills to help improve the effectiveness of current medical licensing assessment methods. A University of Texas Medical Branch project employs computer presented high fidelity video clips that project patients who demonstrate a wide variety of abnormalities of movement that occur in neurological disorders.

In addition to interpreting visible findings, these patient videos can be used to assess the examinee's ability to apply neuroanatomic, pathophysiologic, and diagnostic principles in clinical situations. The investigator intends to determine whether this method is more valid than traditional testing as well as the video clip method's reliability.

Lieberman SA, "High fidelity patient video vignettes in computer-based testing psychometric properties relative to text-based vignettes." National Board of Medical Examiners, Edward J. Stemmler, M.D. Medical Education Research Fund of the NBME 2000-2001 Grant Program.)

The Medical Education Digest also is available for viewing on the Internet at http://medicine.nova.edu/ostmed/admin/sacdev.

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NSU-COM's *Medical Education Digest* has completed almost two-and-a-half years of providing excerpts of information about contemporary issues and initiatives in the education and training of students, residents, and practicing physicians. Your opinions and comments can be very helpful in future issues of the publication. Please take just five minutes of your time to answer the following questions:

1. On a scale of 1-5, five means you agree the strongest and one means you least agree, circle the number of your response:
   
   (a.) The Digest provides useful information about issues/initiatives in medical education.  
       1 2 3 4 5

   (b.) The Digest is easy to read.  
       1 2 3 4 5

   (c.) The Digest is interesting.  
       1 2 3 4 5

   (d.) The Digest should be printed monthly.  
       1 2 3 4 5

   (e.) The format of the Digest should also include at least one comprehensive article.  
       1 2 3 4 5

2. I would like to see the following additions to the *Medical Education Digest*:

   A. 
   
   B. 
   
   C. 
   
   D. 

3. The following are comments that I have about the *Medical Education Digest*:

Thank you. Please return your completed survey by e-mail to: levyleon@nova.edu, or Fax: (954) 262-3536, or mail your response to:

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