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WEB PAPER

Clinical supervisors' perceived needs for teaching communication skills in clinical practice

N. JUNOD PERRON[1], J. SOMMER[1], P. HUDELSON[1], F. DEMAUREX[2], C. LUTHY[1], M. LOUIS-SIMONET[1], M. NENDAZ[1], W. DE GRAVE[3], D. DOLMANS[3] & C.P.M. VAN DER VLEUTEN[3]

[1]Geneva University Hospitals, Switzerland, [2]University of Geneva, Switzerland, [3]University of Maastricht, The Netherlands

Abstract

Background: Lack of faculty training is often cited as the main obstacle to post-graduate teaching in communication skills.

Aims: To explore clinical supervisors' needs and perceptions regarding their role as communication skills trainers.

Methods: Four focus group discussions were conducted with clinical supervisors from two in-patient and one out-patient medical services from the Geneva University Hospitals. Focus groups were audio taped, transcribed verbatim and analyzed in a thematic way using Maxqda© software for qualitative data analysis.

Results: Clinical supervisors said that they frequently addressed communication issues with residents but tended to intervene as rescuers, clinicians or coaches rather than as formal instructors. They felt their own training did not prepare them to teach communication skills. Other barriers to teach communication skills include lack of time, competing demands, lack of interest and experience on the part of residents, and lack of institutional priority given to communication issues. Respondents expressed a desire for experiential and reflective training in a work-based setting and emphasised the need for a non-judgmental learning atmosphere.

Conclusions: Results suggest that organisational priorities, culture and climate strongly influence the degree to which clinical supervisors may feel comfortable to teach communication skills to residents. Attention must be given to these contextual factors in the development of an effective communication skills teaching program for clinical supervisors.

Introduction

Communication skills are best acquired in a clinical context, during all stages of training, and tend to decline with time unless regularly recalled and practised (Flaherty 1985; General Medical Council, 1993; Aspegren 1999; Association of American Medical Colleges, 1999). Most medical schools and hospitals find it still difficult to implement clinically-based, longitudinal communication skills training programs. Coherent models for teaching communication skills in clinical practice have been developed and diffused (Gask et al. 1992; Silverman et al. 2005). However, extending communication training coherently into clerkship and residency and ensuring that clinical faculty supports and teaches communication skills beyond the formal communication course remains challenging (Kurtz et al. 2003).

Clinical teaching of all kinds encounter obstacles such as lack of faculty training and weak support from the hospital hierarchy (Busari et al. 2002; Seabrook 2003; Morrison et al. 2005). Other obstacles are more specific to clinical teaching of communication skills, such as the fact that training programs generally give priority to biomedical aspects of care, and that many physicians harbour negative attitudes towards the teaching and learning of the doctor–patient relationship (Cote & Leclere 2000).

Practice points

- Clinical supervisors' ability to teach communication skills is limited not only by a lack of training but also by time constraints, competing demands and lack of institutional priority.
- In order to be effective teachers of communication skills, clinical supervisors need training in both communication and teaching skills.
- Several organisational changes are required to ensure training transfer: integration of communication skills into formal learning and teaching objectives, a reflective and non-threatening learning atmosphere and development of a work-based coaching system.

Conducting a needs assessment prior to developing a training program can help to identify potential obstacles and inform the development of the curriculum content and format. (Goldstein & Ford 2002; Arthur et al. 2003) In such assessments, three levels of analysis are useful: *organisational analysis* to identify organisation characteristics that may affect the delivery of a training program; *job/task analysis* to identify the activities to be performed in the workplace, the conditions

Correspondence: N. Junod Perron, Division of Primary Care, Department of Community Medicine and Primary Care, University Hospitals of Geneva, 24 rue Micheli-du-Crest, CH-1211 Geneva 14, Switzerland. Tel: +41 22 372 96 79; fax: +41 22 372 96 00; email: noelle.junod@hcuge.ch

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under which the job is to be performed and the knowledge, skills and attitudes needed to perform those tasks (Goldstein & Ford 2002); and *person analysis* to identify the target audience for training and their specific needs.

This article reports on a needs assessment conducted in Geneva which aimed at informing the development of a communication skills training program for clinical supervisors. A previous study had already identified the lack of trained clinical supervisors as a major barrier to communication skills training of residents (Fluckiger & Krenger 2005), so our assessment focused on exploring clinical supervisors' perceived training needs, as well as to identify contextual factors that might facilitate or hinder teaching communication skills in clinical practice.

Methods

Setting and subjects

The study was carried out in two in-patient services (general internal medicine and rehabilitation internal medicine) and one general medicine out-patient service at the Geneva University Hospitals. Thirty-two residents work on the wards of these two in-patient services for a period of 12–18 months and are supervised by 15 chief residents. In the general medical out-patient clinic, 20 residents at the end of their post-graduate training spend a year in ambulatory care before moving into private practice. They are supervised by 10 chief residents. Throughout this article we will refer to chief residents as clinical supervisors.

Data collection

A total of four focus groups were conducted: two with clinical supervisors currently working in one of the in-patient services, and two with clinical supervisors working in the out-patient service (Table 1). All 25 clinical supervisors currently working in the in-patient and out-patient services were invited to participate, 19 were accepted. Reasons for declining included unavailability due to part-time status (1), licensing exams (3), lack of time (2) and lack of interest (1).

The focus group method was chosen because it is an appropriate method to elicit a wide range of ideas and opinions on a well-defined topic. Focus groups are often used for needs assessment in medical education because they can produce useful insights into how to proceed with educational interventions (Tipping 1998).

Procedure

An initial focus group discussion guide was developed and tested with five out-patient clinical supervisors. Because the discussion guide worked well and did not require any changes (Table 2), we included the pilot group discussion in the final analysis.

Each focus group lasted 90–120 min, and was conducted by two physicians who worked outside the participants' departments. This was done to ensure that participants felt free to express their views on communication skills teaching without any hierarchical pressure. Discussions were audiotaped and field notes were written immediately following each session. Audiotapes were transcribed *ad verbatim* by NJP.

Table 1. Focus groups' characteristics.

Focus Group 1	Focus Group 2	Focus Group 3	Focus Group 4
Six in-patient chief residents	Four in-patient chief residents	Four out-patient chief residents	Five out-patient chief residents

Table 2. Focus group discussion guide.

1. In what sorts of circumstances do you discuss physician–patient communication with your residents?
2. How do you approach the subject with your residents?
3. What difficulties have you experienced in trying to address physician-patient communication with your residents?
4. What do you think would help you to better teach residents about physician–patient communication?
5. If you could imagine a training program to help you teach communication skills:
   a. what topics do you think should be taught?
   b. what methods do you think should be used?

The study was approved by the Geneva University Hospitals Research Ethics Committee.

Analysis

The purpose of the analysis was to identify clinical supervisors' perceived training needs as well as any contextual factors that might facilitate or hinder their work as communication skills teachers.

A thematic analysis of verbatim transcripts was conducted in several phases (Miller & Crabtree 1999). During the first phase, a group consisting of two primary care physicians (NJP and JS), a physician working in medical education (FD) and an anthropologist (PH) read and discussed each of the FG transcripts. Based on these discussions, a list of themes was developed.

In the second stage of analysis, a smaller team (NJP, JS and PH) individually hand-coded two transcripts, expanding on the initial thematic list where necessary. This group then met to discuss and resolve any differences in the way themes were understood and applied.

In the third stage, NJP coded the two remaining transcripts with agreed-upon themes using the qualitative data analysis software Maxqda© (Kuckartz 2001). The small group then read coded segments in order to discuss and correct any inconsistencies in the way codes were applied. During these discussions new, cross-cutting themes emerged and were incorporated into the coding scheme. Transcripts were continually re-coded to reflect these emerging themes. Data display tables (key themes by focus group) were then created to facilitate the comparison of responses between clinical supervisors working in in-patient and out-patient settings.

Table 3. List of themes and subthemes derived from the transcripts' analysis.

Code	Themes	Subthemes
C1	Trigger situations for teaching communication skills	Difficult situations: social, chronic, family, type of patients, linguistic/cultural issues
C2	Methods used to teach communication skills	Doing instead of the residents, observing, supporting, giving feedback
C3	Obstacles to teaching communication skills	Lack of training, lack of time, residents' interest, organisational priorities
C4	What would help clinical supervisors to fulfil their role as communication skills trainers	Training level: teaching and communication skills, experiential learning, practice with feedback Organisational level: regular and longitudinal training, external teachers, value given to communication skills
C5	Barriers to participating in communication skills ''training of trainers''	Anxiety, fear of being judged

Results

Findings are presented to reflect the main discussion questions asked to the focus groups. Table 3 shows the key themes and subthemes derived from the transcripts. The first number at the end of each quote indicates the focus group and the participant.

Circumstances in which clinical supervisors teach communication skills

Clinical supervisors from both in-patient and out-patient services felt that use of good communication skills was important for clinical practice. They tended to address communication issues mainly when residents encountered difficulties in their work. For in-patient clinical supervisors, difficult situations included family conflicts and drug-addicted patients, while out-patient supervisors mentioned non-compliance, missed appointments or medically unexplained symptoms.

Although some of the clinical supervisors recognised the importance of addressing communication issues even in unproblematic consultations, they felt that communication issues were more easily identifiable during difficult encounters, and this facilitated the teaching moment.

> Yes, it's interesting because it's relevant not only in usual situations, but also in unusual situations – which include something extra, a tension which is sensed as something difficult. Because unusual situations could also include the mute patient for example [hmm]. We should also ask ourselves [about communication] with a patient who doesn't communicate or who shows no emotions, no hostility towards us. But it is true we don't often tend to do so when the situation is easy to handle. We do it when there's a tension rather than when there is no reaction. (FG2 : P4)

Strategies for teaching communication skills

Clinical supervisors described three approaches to teach communication skills. The most frequently mentioned approach was to simply jump in and "do it instead of the resident". In urgent or tense situations, the clinical supervisor used his communication skills to rescue the resident, calm the situation, maintain control or avoid disaster.

> The problem is that, with this type of organisation, you intervene after the catastrophe. Roughly speaking, you do it when things have gone completely wrong and you have to try to patch them up. You find yourself in a system where you constantly try to put things right. It is not necessarily very easy. (FG1 : P5)

A second strategy was to "stand by the resident". The clinical supervisor acted as a coach, mainly observing and supporting the resident, and only intervened if the discussion went off track. In this role, chief residents thought of themselves as a safety net and as a supportive and reassuring presence.

> Very often the resident comes to you, saying: "Oh, my God, I have to go and tell them about this situation, I have to talk with the family. Can you come with me?" Then he is either ready to lead the discussion on his own, or he expects you to take part in it, or he wants you to do it all on your own. In each case the clinical supervisor's presence is reassuring. (FG1 : P6)

Only a few clinical supervisors mentioned a third strategy: that of acting as a "clinical teacher". These were mainly chief residents that had received some form of teacher training. In this role, clinical supervisors consciously used different methods to enhance residents' learning. These methods focused on identifying and adapting to the individual resident's specific needs, and encouraging residents to draw on their own knowledge and experiences to develop communication skills. They saw themselves as facilitators or co-constructers of communication skills that could be used in difficult situations. As one chief resident described, he tries to . . .

> . . . find out ahead of time where the resident has problems, when those appeared, what he would like to change, which strategies could be put in place to improve the situation. So to start out from various needs expressed by the resident and try to see, during the clinical visit, where they manifest themselves in order to give him relevant strategies and a feedback afterwards. (FG4 : P4)

Difficulties encountered in teaching communication skills

Lack of training and experience

All clinical supervisors were interested in learning about communication skills teaching and most of them believed

that communication skills could be learned and improved through training. However, many clinical supervisors reported a lack of training in communication skills and felt unsure or incompetent in their role of teacher in communication.

> According to what I remember, it seems to me that during our studies we had a few courses dealing with communication, doctor-patient relationships. But afterwards, when we started as residents we never had any training sessions or courses on the subject, as I recall. (FG1 : P2) (7)
> . . . Nevertheless we've never been trained to teach communication and, all of a sudden we become a teacher or an expert and I must confess that, at the time, I found it quite difficult. (FG4 : P3)

In addition, young clinical supervisors expressed a lack of training in more general teaching skills as they switched from the position of resident to the role of supervisor.

> I think what we lack most is not some training in communication, but to be taught how to teach. (FG2 : P4)

Residents' attitudes

Residents' attitudes and degree of interest influenced the extent to which clinical supervisors discussed communication issues with them. Most in-patient clinical supervisors felt that young residents were too overwhelmed by understanding and managing biomedical aspects of care to be receptive to learning something about communication.

> The problem is that at present we have a lot of residents who are far from having proper training yet, so we actually have to start from scratch. How can we spend time on the doctor-patient relationship when so many other things have to be done first, when adjusting an INR (monitoring oral anticoagulant therapy) becomes a problem? In such circumstances, we won't go into doctor-patient relationship; this is where the problem is. (FG1 : P1)

Residents were described as more concerned about rapid problem-solving than about discussing communication issues, especially when time was short. They did not really expect their clinical supervisors to suggest or teach communication strategies. Clinical supervisors also felt that, independently of experience, some residents were just not interested in communication, sometimes unaware of their poor communication skills or did not believe that communication skills could be learned.

Lack of time and priority

Time was an important limiting factor for teaching communication skills in daily practice: many in-patient clinical supervisors complained about the lack of time in daily practice not only to teach communication skills but also to teach in general. In many settings, clinical supervisors themselves felt that patient care and management of medical problems were more important.

> It's clearly not a priority in comparison with [other] needs, with what we would like to achieve. I would even say that medical teaching is not a priority; the priority is certainly to deal with what is most urgent. We are in such and such a situation, it is summer, there are staff members on holidays [laughter] To me the time factor is something that limits me. I don't know if it's the only thing, but . . . (FG1: P5)
>
> I would just like to say: one of the things I find difficult, as my colleague was saying, are emergency consultations, whether at the walk-in clinic where you must sort out the problem quickly or at the follow-up consultation where you have appointments every half-hour which you must also keep. And here what I would like to say is that what I often do – and it's probably not a good thing – is that I take the matter into my own hands, which means I'm the one who does the communicating, who goes straight to the patient to talk to him, etc . . . hem, because I feel stressed by (the lack of) time and I tell myself – I imagine I am not always an example of what should be done – I tell myself: "The resident may or may not be able to deal with the situation, but here there is no choice, we're pressed for time. This is frustrating. (FG4 : P4)

Finally, barriers were found at higher levels of the medical organisation. Some clinical supervisors pointed out that the fact that even if clinical supervisors were trained, it would not mean that teaching communication skills would become a service priority or an institutional goal. The fact that demonstration of appropriate communication skills were not needed to obtain the title of specialist in most of medical fields was also described as a barrier.

> This is where we come up against the problem a little. As is said, in internal medicine all you have to do is look at the FMH (Swiss medical association) exam, at the priorities the written part reveals. These don't have much to do with the world that the internal medicine private practitioner is confronted with. And communication isn't on the forefront either for residents who work in various regional hospitals. What matters is biomedical medicine and not communication skills (FG4 : P2)

Suggestions for better training clinical supervisors to teach communication skills

Clinical supervisors had difficulty describing the content of an ideal training program in teaching communication skills, but some did mention that it should focus on both communication and teaching skills. They expected the training to rely on active and experiential learning methods such as group learning, observing, being observed and receiving feedback.

Most of the participants from both settings said they would prefer a longitudinal training including a theoretical introduction of 1–2 days followed by either refresher courses two to four times a year or regular coaching in daily practice through videotaped supervisions and direct observation.

A striking feature was that a majority of in-patient clinical supervisors wanted to learn with external teachers to avoid being judged by their hierarchy.

> I'd say that, in order to this judgement situation, it should perhaps be done – I am rather in favour of it - by people who don't have anything to do with our daily activities. They would only deal with communication, not necessarily doctor-patient communication, but just communication between people, which is probably not very different. They should have no hierarchical power, because we obviously never like it very much when we have in front of us someone we work with and interact with every day, or someone who must assess us at the end of the year to decide whether to hire us again for the following year. This will obviously cool our enthusiasm down a bit, unlike with someone who is a stranger to our socio-professional circle and who clearly comes to help us improve rather than to judge us. I would be quite for it. (FG1 : P4)

A few experienced clinical supervisors from the in-patient setting worried that taking part in a training program as learners might lead to self-doubt their professional competence.

> All this gets to you, you expose yourself. If all of a sudden you're told that your way of going about it is all wrong, you've got a problem. It may be very hard to take if you've functioned this way for the last ten years. That's the reason why I think some people will adapt easily, while for others it may be a big problem, and this might be a barrier. (FG1 : P5)

Discussion

The results of the needs assessment suggest that clinical supervisors often address communication issues with their residents, especially in difficult and conflict situations but intervene more often as rescuers, clinicians or coaches than teachers. Although interested to teach communication skills, clinical supervisors feel unprepared to fulfil this role.

Other barriers to teaching communication skills include lack of time, competing demands, lack of interest on the part of residents, and finally lack of priority given by the institution to communication issues. Clinical supervisors felt that in order to be effective communication skills teachers, they needed to strengthen their own communication skills and learn how to teach these skills. For this to happen, they felt that a non-judgemental learning environment and the use of experiential learning methods were needed.

Lack of faculty training appears as an important barrier to teaching communication skills (Novack et al. 1993). Many clinical supervisors report little training in communication and do not feel confident enough to teach skills that they themselves have not mastered. In addition, they lack teaching skills and most of them expect that by simply watching and listening, residents will recognise, accept and embody desirable behaviours and skills (Weissmann et al. 2006). They are encouraged to demonstrate effective and ineffective communication via role-modelling (www.acgme.org). However, effective role modelling occurs when clinical teachers are aware of how they themselves use such skills and know what learners should understand in order to make this modelling explicit (Cote & Leclere 2000) and this requires use of both communication and teaching skills. Our findings correlate with expert recommendations. Indeed, one of the most developed program for teaching communication skills reported in the literature provides training to GPs not only on how to teach communication but also on effective generic teaching strategies and on teachers' own communication skills (Draper et al. 2002). Viewing their own consultation in a group feedback setting appeared to greatly influence trainers' teaching skills (Gask et al. 1992).

There are several other barriers in teaching communication skills. Time availability is a major issue. It has already been show that clinical supervisors' first mandate is to address the medical needs of patients (Yedidia et al. 1995) and when time is limited, other mandates such as teaching and research often become secondary. Although it is not always clear whether lack of time reflect the actual lack of time for supervision or the perception of lack of time due to poor didactic skills (Busari & Koot 2007), it suggests that teaching in general and more specifically communication skills teaching are not priorities in working settings.

Clinical supervisors described residents as only moderately interested into communication skills learning. Residents' attitudes towards communication skills and expectations towards their clinical supervisors may result from inexperience, lack of time and need to focus first on mastering biomedical aspects of care. It may also reflect clinical supervisors' discomfort in teaching them and tendency to give priority to other learning issues (Cote & Leclere 2000). Finally it may indicate that the institution itself gives little value to communication skills and its training (Laidlaw et al. 2002; Rees et al. 2002; Willis et al. 2003). This process, called the "hidden curriculum" has been largely described in undergraduate medical education (Suchman et al. 2004) but less often at the post-graduate level (Hafferty 1998).The fact that the interpersonal and communication skills are defined now as one of the core medical competences and that their assessment in residential programs becoming mandatory in many countries may change such culture and increase institutional support for such training (www.acgme.org; www.rcgp.org.uk)

Finally, the fact that some clinical supervisors express considerable anxiety to go through the process of learning and reflecting may indicate that beyond the fact that the learning process challenges the concepts of self and self-esteem, the learning environment of the working setting can participate in increasing clinical supervisors' resistance, anxieties and vulnerabilities. Learning organisations should be characterised by a positive learning environment where mistakes are tolerated during learning and constraints to learning are minimised (Goldstein & Ford 2002).

According to clinical supervisors' perceptions, some settings promote neither a friendly and non-judgmental learning atmosphere nor a reflective culture and do not qualify as learning organisations. Communication skills training sessions that lead to better learning if they encourage self assessment are associated with well-intentioned feedback and are provided in a secure atmosphere (Silverman et al. 2005).

Strengths and weaknesses

There is very little literature about post-graduate experiences of teaching in communication skills. In the UK, for example, most training programs in communication skills take place in vocational training (Gask et al. 1991, 1992; Silverman et al. 1996; Neal et al. 1998;). However, only a small part of such training seems to be published (Sackin 2000). To our knowledge, our study is the first published report on a needs assessment in post-graduate communication skills teaching. The use of focus groups provided rich and practical information about the task, personal and organisational dimensions of learning (Goldstein & Ford 2002). However there are some limitations to our study. We interviewed a convenience sample of physicians from three medical services. Due to our small sample, we are not sure whether we reached the point of saturation. However, the frequency of repetitive statements suggests that extending our enquiry to a greater number of physicians would not have yielded very different needs. The results might be skewed in favour of the ambulatory care setting analysis group because of a higher rate of participation among out-patient clinical supervisors. Finally, the analysis group included two out-patient clinical teachers and an anthropologist but no in-patient clinical teacher, raising the possibility that the analysis was influenced by the particular setting that researchers worked in or by the opinions they held of other services. However, when we discussed the results of our analysis individually with the three in-patient clinical teachers involved in the project, they confirmed the relevance of our findings for the in-patient setting.

Implications for the future

Our results support the recommendation made by others that clinical supervisors should be trained in both communication and teaching skills (Draper et al. 2002). Clinical supervisors ask for both experiential learning and reflective practice beyond the training program itself, with longitudinal practice with feedback and coaching in the working setting. Our results stress the importance of involving external supervisors as trainers in this programme in order to avoid any hierarchical pressure or judgement and decrease the feeling of anxiety and threat that may compromise the learning process. It appears imperative to address potential obstacles to training transfer such as time limitations and lack of residents' interest, and to discuss strategies to overcome these problems in order to prevent relapses in the learned skills (Goldstein & Ford 2002).

Our results also suggest the need for consistency between the training program and the organisational mission, values and readiness (Levinson et al. 2002; Stein et al. 2005). Major organisational changes are required to make this training successful: First, in order to make organisational goals consistent with the training programme, communication skills should be integrated into residents' formal learning objectives, communication skills teaching should be included in clinical supervisors' mandates, and communication skills training should be inserted into regular learning activities. Mandatory assessment of residents' communication skills may strongly change the institutional culture. Second, more efforts must be provided to make learning less threatening. Clinical supervisors should be strongly encouraged to question and reflect on their knowledge, attitudes and skills since this contributes not only to personal growth but also enhances teaching effectiveness (Cole et al. 2004). Third, sufficient time and human resources are needed to ensure a work-based coaching system for the maintenance of newly acquired skills.

Finally, a needs assessment gives several important cues about what outcome criteria and measures should be integrated into the evaluation of the training program. Beyond reaction and learning levels, changes in clinical supervisors and residents' performances and the overall organisational climate should be assessed (Kirkpatrick, 1976, 1996).

Conclusion

Our study demonstrates that a qualitative needs assessment is useful in defining not only the content and instructional methods of a training program but also the learners' characteristics and the organisational dimensions of learning. Results suggest that institutional priorities, culture and climate strongly influence the degree to which clinical supervisors may feel comfortable to teach communication skills to residents. Attention must be given to these contextual factors in the development of an effective communication skills teaching program for clinical supervisors.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

Notes on contributors

NOELLE JUNOD PERRON, MD, MHPE, is currently chief resident at the Division of primary care, Geneva University Hospitals. She is involved in undergraduate, post-graduate and continuing medical education and especially committed to communication skills teaching.

JOHANNA SOMMER, MD, is a faculty member at the Division of primary care, Geneva University Hospitals. She is the program director of primary care training and is involved in communication skills and faculty development teaching activities.

PATRICIA HUDELSON, PhD, is a medical anthropologist. She teaches and conducts research on cultural aspects of health and health care, and is responsible for interpreter services at the Geneva University Hospitals.

FLORENCE DEMAUREX, MD, works at the medical education development and research unit at the Geneva University. She is responsible for the standardised patients program and is involved in communication and clinical skill teaching activities at the undergraduate level.

CHRISTOPHE LUTHY, MD, is a faculty member at the Department of rehabilitation and geriatrics. He is involved in communication skill

teaching activities at the under- and post-graduate level. His areas of research are congruence between physicians and patients perspectives.

MATHIEU NENDAZ, MD, MHPE, is a faculty member at the Department of internal medicine and the medical education development and research unit. His area of research focuses on clinical reasoning.

MARTINE LOUIS-SIMONET, MD, is director of the communication skill training program at the Geneva medical school. She is a faculty member at the Department of internal medicine. Her areas of research are communication skills at the pre- and post-graduate level, patients' knowledge and education on discharge medication and discharge planning.

WILLEM DE GRAVE, PhD, is Coordinator of the Faculty Development Project. Major interests are in the areas of PBL and faculty development. Research is focused on PBL (e.g. cognitive processes in tutorial groups, the role of the tutor) and faculty development (e.g. effectiveness of training activities).

DIANA DOLMANS, PhD, is associate professor and the Programme Director of the PhD Programme School of Health Professions Education at the Department of Educational Development and Research, Faculty of Health, Medicine and Life Sciences, Maastricht University. Her interests are problem-based learning, collaborative learning, workplace learning, teacher learning, teacher evaluation and quality assurance.

CEES VAN DER VLEUTEN, PhD, is the Scientific Director School of Health Professions Education and Chair Department of Educational Development and Research at the Department of Educational Development and Research, Faculty of Health, Medicine and Life Sciences, Maastricht University. His particular expertise concerns assessment of professional competence, including modern methods of assessment and strategies for designing assessment programmes.

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