Use of Checklists Teaches Communication Skills Utilized by Specialties

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Abstract

Objectives: The purpose of the current study was to implement the use of communication checklists and determine whether medical students were able to attend to and distinguish differences in communication skills between various physician specialties.

Methods: As part of a newly-revised medical education curriculum, all first-year medical students at a mid-Atlantic medical school were required to complete a communication skills checklist while observing 10 clinical encounters performed by attending physicians. The checklists were collected and analyzed for trends found within the reporting.

Results: Even novice learners distinguished complex medical communication skills when structured observation checklists were used as a teaching tool. Significant differences were noted in demonstrations of targeted communication skills when analyzed by physician specialty and gender.

Conclusions: Structured observation checklists can be used as an instructional tool for exposing medical students to advanced physician-patient communication skills, providing students with guidance on what skills to observe and identify, and highlighting the differences in implementation of these skills across specialties.

Practice implications: This study provides implications for faculty development as well as medical communication curriculum. Communication checklists can assist in providing structured observations and normative feedback for learners and faculty desiring to improve their physician-patient communication skills.

Keywords: Physician-patient communication, teaching physician communication skills, medical education, communication curriculum for medical school, specialty-specific communication skills
1.0 Introduction

Teaching and assessing communication and interpersonal skills are essential components of medical school curriculum (LCME, 2013). Expert panels recognize the crucial role of high quality medical communication in improving health outcomes with organizations, including the Office of Disease Prevention and Health Promotion advocating for increased education for health professionals regarding patient health literacy particularly in rural areas, due to educational attainment that is lower than the national average (Levinson et al., 2010; Office of Disease Prevention & Health Promotion, 2010). Patient-centered relationship skills and high-quality communication skills especially are important in addressing the needs of the medically underserved and those with chronic health conditions. To be an effective clinician, healthcare trainees require intensive instruction in communicating and relating to patients in empathic ways to encourage wellness, health-promoting behaviors, and self-management of chronic illness.

Medical educators have been developing innovative means of providing assessment and instruction regarding complex communication behaviors. Nonetheless, medical student observation or "shadowing" of physicians during medical encounters remains a mainstay of training. Student observation of physicians often occurs during complex medical encounters in a variety of settings and across a range of specialties, making it difficult for students to distinguish the information to which they should attend; however, it is necessary for students to observe advanced communication skills in order to be able to learn and model the skills themselves (Deveugele et al., 2005). These shadowing experiences remain an important part of training, and with modification these encounters could be better utilized to introduce and establish a variety of communication skills. Additionally, students could begin to understand the skills needed across different specialties, and begin to develop these skill sets on their own. Previous research has demonstrated that medical providers differ in their demonstration of communication skills by experience, gender, and training (Dielissen et al., 2012; Handford et al., 2013). According to Roter, Hall, and Aoki (2012), when gender is included in the analysis of physician communication skills within a primary care setting, females have been found to be more patient-centered in their interactions than males. Additionally, female physicians in primary care often spend longer amounts of time with their patients than their male counterparts (Roter et al., 2012). While many speculate about relative communication skill level among medical specialties, observational data is rare. It is likely that communication skills vary in terms of effectiveness especially in complex patient care situations; however, there is a paucity of research examining these assumptions. Additionally, medical educators may incorrectly assume that all students have observed advanced communication skills, such as physician modeling of relationship-centered interactions, egalitarian healthcare decision making with patients, and team-based communication required for treating chronic illness, while shadowing physicians during medical encounters. Instead, students may observe relatively poor-quality communication skills or be unaware of what particular communication components to attend to in an encounter.

Furthermore, studies suggest most medical educators have minimal, if any, training in communication assessment and education, and the teaching of such skills is inconsistent (Arnold et al., 2009). Such inconsistency is likely due in part to lack of agreed-upon terminology for communication curriculum, and results in imprecise evaluation and guidance in skill development. In order to effectively teach these skills, educators need to be able to define and operationalize skills, and students need to be able to differentiate and understand the skill components before they can model them independently. Without defined skills, educators and students are unable to accurately assess skill competence, and non-specific praise and vague feedback on performance may lead to confusion and frustration in learners (Hewson & Little, 1998). These issues coupled with documented concerns about communication skills training of medical trainees, including inconsistencies in the medical curriculum, limited opportunities for direct observation of students, and lack of effective feedback (Sigall et al., 2008), inspire a need for modification of
communication training strategies and consistent implementation of communication education across departments and disciplines.

With this need in mind, a medical communication curriculum was created at West Virginia University School of Medicine incorporating structured observations of faculty performing patient encounters during the preclinical years as well as experiential communication workshops and direct observations of students with patients during the clinical years. The communication checklist focused on three of the seven core elements established by the Kalamazoo consensus statement on medical communication, chosen by the authors to promote visit efficiency and patient-centered relationship skills (Makoul, 2001). With the checklist development, the authors aimed to standardize the definitions of targeted verbal and non-verbal communication skills across required shadowing experiences.

The purpose of the current study was to determine whether first-year medical students could differentiate complex medical communication skills being demonstrated by faculty physicians through use of an observation checklist to provide structure and direction, without increasing demands on faculty physicians. To determine if students were able to recognize targeted communication skills, a comparison of medical student ratings of attending physicians’ communication behaviors on the observation checklists was utilized. Therefore, if communication skills differed by gender and specialty in expected directions as identified by medical student observers, then these novice learners may be effectively using the observation checklists as an instrument to recognize and differentiate complex communication skills. The authors anticipated two main findings: (1) Physicians specializing in continuity of care, care of chronic illnesses, care of children, and treatment of patients with terminal illnesses would demonstrate higher scores on ratings of targeted communication skills than physicians specializing in acute care or surgical specialties, and (2) Physician gender would affect demonstrated communication skill level, specifically; female physicians would provide more patient-centered care than male physicians.

2.0 Methods

A communication observation checklist, based on previous work by Mauksch and colleagues at University of Washington (Chesser et al., 2013), was created for medical student observations of physicians. This checklist covered the following constructs: establishing rapport, developing a doctor/patient relationship with use of empathy, collaborative agenda setting, maintaining visit efficacy, gathering information, assessing the patient’s perspective on their health, use of the electronic health record, communication throughout the physical examination, shared decision making, behavioral change discussions, closure and follow-up, and team collaboration (See Table A.1.).
Communication curriculum at this medical school at the time of the study involved training and feedback on the targeted communication skills. Students received didactic instruction during the first week of medical school, as well as definitions and demonstrations (via video clips) of effective and efficient patient-centered communication skills.

| Domain                  | Description                                                                 |
|-------------------------|-----------------------------------------------------------------------------|
| Establishes Rapport      | Introduces self and explains healthcare role                                  |
|                         | Uses eye contact                                                           |
|                         | Greeting and smile                                                         |
|                         | Humor or non-medical interaction                                             |
|                         | Acknowledges all in the room by name                                        |
|                         | Sits down for interview                                                    |
| Relationship/Empathy    | Verbal empathy (leans in; nod; hand on shoulder)                           |
|                         | Listens well using continuer phrases                                        |
|                         | Responds to emotion: crying, wringing hands, silence                       |
|                         | Repeats important verbal content (uses patient’s words)                    |
|                         | Demonstrates mindfulness through curiosity                                  |
| Collaborative Agenda Setting | Use open-ended inquiry to begin visit                                      |
|                         | Acknowledges agenda items from other team member                           |
|                         | Additional elicitation of topics for day until patient is finished         |
|                         | Confirms what is most important to patient                                |
| Maintains Visit Efficiency | Discuss visit time use / visit organization                           |
|                         | Prioritize problem list                                                    |
|                         | Negotiate agenda for today with patient                                   |
| Gathering Information   | Uses open-ended questions                                                  |
|                         | Allows patient to tell their story without interrupting                     |
|                         | Uses summary/clarifying statement                                           |
| Assessing Perspective on Health | Acknowledges patient verbal or non-verbal cues                        |
|                         | Explores patient beliefs or feelings about illness                         |
|                         | Explores contextual influences: family, cultural, spiritual aspects.      |
| Electronic Health Record | Describes use of Electronic Health Record to patient                      |
|                         | Positions monitor to be viewed by patient                                  |
|                         | Maintains eye contact with patient majority of time while using Electronic Health Record |
|                         | Points to screen                                                           |
| Physical Exam           | Prepares patient before physical exam actions                             |
|                         | Washes hands before touch patient                                          |
|                         | Describes exam findings during the exam                                    |
|                         | Stethoscope on skin                                                        |
| Shared Decision Making  | Shares evidence behind recommendations                                      |
|                         | Describes alternative options                                              |
|                         | Asks for patient input and, if needed, modifies plan                       |
|                         | Asks for patient preferences                                               |
| Behavior Change Discussions | Explores patient knowledge about behaviors                               |
|                         | Explores pros and cons of behavior change                                  |
|                         | Scales confidence or importance                                            |
|                         | Asks permission to give advice                                              |
|                         | Reflects or summarizes patient thoughts and feelings                       |
|                         | Creates a plan aligned with patient’s readiness                           |
|                         | Affirms behavior change effort or success                                  |
| Closure and Follow-Up   | Asks for questions about today’s topics                                    |
|                         | Provides written information or plan (script or EHR)                      |
|                         | Clarifies follow up plans                                                  |
| Team Collaboration      | Introduces other members of team if present                                |
|                         | Describes roles of other team members                                       |
|                         | Provides referral information to other professionals                       |
This early instruction included in-class practice with the communication observation checklist to ensure familiarity with the skills and checklist use. First-year students were required to complete the structured observation checklist during each of 10 shadowing experiences with physicians across specialties. These shadowing experiences were discussed with their student peers and a faculty facilitator in small group meetings to review communication best practices. Observation checklists from these shadowing encounters were collected and analyzed based on both individual faculty and specialty scores on each communication domain. Appendix A contains the observation checklist used by students for each observation experience.

Medical students were randomly assigned to faculty physicians who had agreed to participate in shadowing experiences. For the purpose of data analysis, physician scores were grouped based on their departmental specialty. Table A2 lists those departments represented by this sample, the number of physicians in each department that were observed, and the number of students that observed physicians in each department.
Specific departments were grouped into primary care or specialty care categories. Arguably, there were multiple ways in which the specialties could be divided. For example, groupings of physician specialties were designated as "people-oriented specialties" and "technology-oriented specialties" during the development of the Jefferson Scale of Physician Empathy (Hojat et al., 2001; Hojat et al., 2002). The current groupings were based upon the results of consensus among the co-authors and were viewed as indicating those physician-patient relationships which tend to occur over a length of time and address more comprehensive aspects of care (i.e., primary care) versus more short-term, acute, and focused visits (i.e., specialty).

Table A.2. Summary of Department Grouping

| Group     | Department                | # of Physician Evaluated | # of Students’ Evaluations |
|-----------|---------------------------|--------------------------|----------------------------|
| Primary   | Community/Occupational Med| 2                        | 7                          |
|           | Family Medicine           | 11                       | 101                        |
|           | Infectious Disease        | 4                        | 16                         |
|           | Internal Med-Endocrinology| 1                        | 2                          |
|           | Internal Med-Geriatrics    | 1                        | 12                         |
|           | Internal Med-Pulmonary     | 2                        | 26                         |
|           | Labor & Delivery           | 5                        | 36                         |
|           | Neurology                  | 6                        | 29                         |
|           | Oncology                   | 11                       | 96                         |
|           | Pediatrics                 | 12                       | 70                         |
| Total Primary |                         | **55**                   | **395**                    |
| Specialist| Dermatology                | 1                        | 13                         |
|           | Emergency                  | 18                       | 76                         |
|           | Emergency/UC               | 4                        | 64                         |
|           | Neurosurgery               | 4                        | 33                         |
|           | Ophthalmology              | 7                        | 33                         |
|           | Orthopedics                | 6                        | 38                         |
|           | Otolaryngology-ENT         | 5                        | 41                         |
|           | Pediatric Intensive Care   | 4                        | 28                         |
|           | Podiatry                   | 2                        | 22                         |
|           | Radiology                  | 9                        | 69                         |
|           | Surgery                    | 4                        | 32                         |
|           | Urology                    | 7                        | 33                         |
| Total Specialist |                   | **71**                   | **522**                    |
| TOTAL     |                           | **126**                  | **917**                    |
The numbers of observations collected for individual faculty physician varied greatly. Each construct was made up of multiple observed behaviors that were listed on the checklist. To avoid the problems of correlation between observations and unequal sample size comparison, we used the mean scores on each construct for each physician, so each physician had only one observation in the data despite number of student observations. The physician received one point for each behavior and these points were then added together to create the score for each construct. The data were analyzed using Statistical Analysis Software (SAS version 9.3, 2012, SAS institute Inc., Cary, NC). Because the variables of communication skills were not normally distributed, non-parametric Wilcoxon rank-sum test and Kruskal-Wallis test were performed for comparison of communication skills between gender and homogenous groups; p<.05 was considered statistically significant for all the differences. Following by the significant Kruskal-Wallis test, SAS version 9.3 macro implementation of a Dunn pairwise multiple comparison test among the three groups was used to identify which groups were significantly different. Alpha=.05 was used for the SAS macro to determine if two groups would be statistically different based on the comparison of the calculated q-statistic to the q-table value.

3.0 Results

Over the course of two academic years, 917 observations were conducted by first-year medical students of 129 attending physicians performing clinical encounters within the medical school. Of those physicians observed, 70% were male. Similar observed scores were obtained by physicians grouped into primary care categories across communication domains. Based on student observations, communication scores of physicians in the primary care category were significantly higher (p<.05) than scores for physicians in the specialty category on all skills targeted on the observation checklist, including establishing rapport, relationship/empathy, collaborative agenda setting, maintaining visit efficacy, gathering information, assessing the patient's perspective on their health, electronic health record, physical exam, shared decision making, behavioral change discussions, closure and follow-up, and team collaboration. (See Table A.3.)
When including the consideration of gender into communication differences among physicians, females were rated significantly higher by students on communication skills than males in the areas of relationship/empathy, collaborative agenda setting, maintaining visit efficiency, gathering information, assessing perspective on health, physical exam, shared decision making, behavior change discussions, closure and follow-up, and team collaboration. There were no significant gender differences in the domains of establishing rapport or use of the electronic health record, based on student observations. (See Table A.4.)
4.0 Discussion

The results suggest that first-year medical students were able to effectively use structured observation checklists to differentiate between various physicians’ frequency of utilizing the targeted communication skills during patient encounters. As hypothesized, differences in communication skills were observed between primary care and specialty groupings of physicians as well as between physician genders. The significant differences occurred in expected directions, lending credibility to the use of such checklists as a possible teaching tool in medical education. Building evidence for the use of a communication skills checklist as a teaching tool was the primary aim of the study. As such, results of this study should not be viewed as indicative of physician strengths or deficits relative to area of specialty, but rather as possible evidence of the checklists’ ability to structure these observations.

4.1 Practice Implications

This study provides implications for the use of checklists for teaching and structuring student observations, as well as standardizing and streamlining assessment and feedback during the development of physician-patient communication skills. Providing structured observation checklists may be beneficial in focusing attention on
communication best practices for learners. Medical students have indicated improved satisfaction with required physician observation experiences using the checklists, noting the structure of the assignment provides guidance and objectivity to an otherwise subjective task (2013 personal communication; unreferenced). Repeated observations using the checklists provide opportunities for increased discernment of developing skills and exposure to assessment tools prior to being evaluated. Such checklists also provide a shared vocabulary for medical educators attempting to teach communication skills.

Similarly, use of structured observation checklists embedded throughout the curriculum provide a means of objective assessment of student progress. Such structure provides both specific goals to target and an objective measurement of skill attainment in patient-centered communication that, without such structure, can otherwise appear nebulous. Repeated assessment of communication skills throughout training and in a variety of patient situations also is important as skill level may decline from preclinical to clinical years, as suggested by studies of empathy (Chen et al., 2007). Additionally, these communication skills are essential to graduation requirements, as medical educators must indicate whether graduating medical students possess the requisite skills needed to provide the level of medical care entrusted to them as house staff (i.e., "Expected behavior for an entrustable learner"; AAMC, 2014). The Association of American Medical Colleges includes communication skills in the expected skills for students entering residency, including, "Obtaining a complete and accurate history in an organized fashion" and "Demonstrates patient-centered interview skills." Therefore, the communication checklist can provide an objective and standardized method of assessing these skills.

Beyond the medical student, the checklist may be utilized for faculty development by providing feedback to attending physicians on their communication skills without adding more demands on their time. Although faculty physicians in teaching hospitals often are observed, feedback on observed behaviors is rare. Establishing a sufficient pool of structured observations for each specialty could provide normative data on communication skills that are relevant to patient-centered care in general as well as specialty-specific skills. Providing feedback to faculty on their doctor-patient communication skills ratings relative to other faculty in their specialty could offer valuable insights for reflection and improvement. Moreover, faculty may be more receptive to observational data from students than from results of patient-satisfaction surveys. The latter may be more subject to sampling bias (i.e., patients who are very satisfied or very dissatisfied may be more likely to return surveys) than the former in a medical curriculum requiring that all students complete observation checklists during clinical observational experiences.

Additionally, peer observation and feedback by physician colleagues could help improve communication and relationship skills in not only the observed physician, but also the observer. As noted by Mauksch et al. (2013), even experienced clinical educators reported improvement in their own skills when teaching medical communication via observation and feedback. Faculty development using peer observation of communication behaviors and structured feedback for enhancing skills could contribute to a more constructive and effective culture of observation and feedback in these essential clinical skills; however, such peer observation by physicians is not only rare, but costly given the time demands in busy academic medical settings. Incorporating a means of providing feedback to faculty into a required assignment for students, as in the current medical communication curriculum, is efficient and cost-effective.

Finally, if medical providers differ in their demonstration of communication skills by specialty and gender, it may be important to take these findings into consideration when assigning medical students to physician observation experiences when targeting specific communication skills. A sufficiently broad range of physician shadowing assignments may be necessary to provide a comprehensive picture of physician communication behaviors for medical student observers. Medical educators responsible for communication curriculum should consider both cueing student attention to best practices by structuring the observation experience, as well as varying the gender and
specialty of the attending physician being observed.

4.2 Study Limitations and Strengths

This study contains several limitations; as such the findings should be viewed as important pilot data in the implementation of a staged school-wide communication curriculum redesign. The study was conducted in one academic medical center using faculty physicians who have volunteered to be observed by first-year medical students, obviously limiting transferability of findings. It should be noted, however, that these physicians are faculty of a medical school, with resulting implications for regularly teaching medical trainees at various levels of training. It is unlikely that these physicians vary in reliable ways from other academic medicine physicians that were not observed, suggesting that they are likely representative of their practices. Second, the required observations by students have been part of the curriculum for several years, and many faculty physicians were unaware of communication-focused observation checklists in use. Thus, physicians being observed were unlikely to modify their behavior for the specific checklist items.

Likewise, individual student observation experiences could have varied widely in the half-day observation periods. Given a broad range of clinic and hospital settings, students could have observed one or several patients with each physician, inpatient or outpatient, scheduled or emergency, new patient or return patient. Participating physicians vary in years of practice, gender, and country of origin. The amount of time spent with patients would likely vary considerably. It is hoped that this very broad range of observation experiences provided breadth, in contrast to depth, of observed physician communication behavior to first-year medical students.

Student performance of observation checklists did not include multiple observers of the same physician encounter, leaving questions about reliability of the ratings. Observations and the subsequent ratings could be separated by several days, as students were required to hand in their checklists weekly, leading to possible memory degradation if checklists were not completed at the time of the observation. Also, it is unclear to what extent different types of patient presenting problems or clinic structure and organization affect the communication skills demonstrated by the physicians.

4.3 Future Directions

Future directions include determination of whether particular observational experiences during medical student preclinical years (e.g., higher proportion of primary care observations versus specialty care) affect communication performance in later clinical clerkships. Determining whether particular observational experiences during training impacts specialty preference may have policy implications given the looming shortage of primary care providers, as suggested by Chen and colleagues in their reflection on differences in average empathy ratings of various physician specialists (Chen et al., 2007). Another direction for future study is to establish norms for specific communication tasks at various levels of training and for various medical specialties to develop "benchmarks" for expected progress and need for potential remediation experiences. Development of normative data on communication skills that are specifically relevant to various medical specialties can be used to create competency milestones for resident physicians in task-specific skills. LeBlanc et al. (2009), incorporated checklists to assess surgical procedural skills simultaneously with patient-centered communication skills in simulated scenarios, with results indicating residents outperformed medical students in procedural skills, but only on one domain of the communication skills being assessed. Such findings are provocative in their indications for application of observation checklists to residency milestone attainment and finding and addressing gaps in training.
5.0 Conclusions

All future physicians will require advanced communication skills for enhancing health-promoting behaviors and improving a patient's chronic illness self-care behaviors. In addition, medical educators can benefit from increased self-awareness of their role in teaching physician-patient relationship skills, and also may benefit from improved efforts focused on teaching and modeling effective physician communication behaviors. Medical schools may want to carefully consider the impact of role modeling by various physician specialists on student learning. Medical educators responsible for communication curriculum should consider both cueing student attention to best practices by structuring the observation experience, as well as varying the gender and specialty of the attending physician being observed. As studies accumulate indicating the health benefits for patients whose physicians display empathy (Kelley et al., 2014), structured measurement of well-defined skills in clinical settings may become increasingly important to patients seeking care, insurers seeking best practices for patients in their panels, and for employers seeking objective ways to quantify various levels of performance on patient-centered care indices. Structuring the observational learning process using communication checklists may facilitate future medical professionals in attaining these multidimensional goals.

Take Home Messages

Practice Points

- Shadowing experiences are a mainstay of medical education, but often have little structure or guidance related to what the student should attend to in the visit.
- Patient-centered relationship skills and high-quality communication skills are important in addressing the needs of the medically underserved and those with chronic health conditions.
- The use of communication skills checklists for teaching and structuring student observations provides a more standardized and streamlined process for assessment and feedback during the development of physician-patient communication skills.
- Communication skills checklists may be utilized for faculty development by providing feedback to attending physicians on their communication skills without adding more demands on their time.
- By utilizing structured communication checklists, physician-patient communication skills can be tracked and improved over the course of the students’ training. Improvement in communication skills, such as empathy, has been shown to result in behavior change and improved health benefits for patients, thus helping students to become more effective physicians.

Notes On Contributors

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Dorian Williams, MD is a Professor of Family Medicine and Director of Student Programs. As Director of the Physical Diagnosis Course for the School of Medicine, he has interests in Communication, Patient Safety, and Simulation in Medical Education. He has over 20 years of experience with curriculum development and evaluation.

Jun Xiang, MS, MA, is a health data analyst in the Department of Family Medicine at West Virginia University. Her main responsibility is to assist faculty and residents in the department for study design, statistical analysis, and report writing.

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Appendices
## Family Medicine Clerkship Observed/SP/RP Grading Sheet

| Skill | N/A |
|-------|-----|
| Introduction: | □ Introduce self □ Explains role in patient's care □ Sits down □ Non-medical interaction □ Open-ended question to elicit patient's concern □ Allows patient to explain concern without interrupting |
| □ N/A |
| Visit Organization: | □ Open-ended inquiry to begin visit □ Elicits other concerns for day (something else?) □ Confirms what is most important to patient □ Negotiates agenda with patient input |
| □ N/A |
| Electronic Health Record: | □ Describes use of EHR to patient □ Positions monitor to be viewed by patient □ Points to screen |
| □ N/A |
| Verbal Empathy: | □ Expresses support (sounds tough) □ Uses continuers phrases (um hmmm) □ Repeats important verbal content (uses patient’s words) □ Appropriate tone of voice |
| □ N/A |
| Non-verbal empathy: | □ Eye contact □ Leans in □ Nods □ Responds to emotion □ Use of silence □ Listens without writing notes during emotional content |
| □ N/A |
| Basic Skills: | □ Mostly open-ended questions □ One question at a time □ Allows patient to ask questions □ Avoids leading questions □ Avoids or explains medical jargon |
| □ N/A |
| Assesses Perspective on Health: | □ Explores patient beliefs or feelings about their overall health or their illness (What are you concerned this could be?) □ Affirms patient healthy behaviors/strengths |
| □ N/A |
| Physical Exam: | □ Prepares patient before physical exam actions (Do you mind if I ____?) □ Washes hands before touches patient □ Stethoscope on skin □ Describes exam findings during the exam (Your lungs sound healthy) |
| □ N/A |
| Closure: | □ Summarizes main points □ Asks for questions □ Courteous closing remarks |
| □ N/A |

### Qualitative Strengths/Challenges

### OPTIONAL ITEMS: USMLE STEP 2 CS TARGETED SKILLS

| Preventative Care: | □ Ask about knowledge of health behaviors □ Explores pros and cons of behavior change □ Asks permission to give advice □ Creates a plan aligned with patient’s readiness □ Affirms behavior change efforts |
| □ N/A |
| Negotiate Plan: | □ Communicates findings □ Outlines options □ Shares evidence behind recommendations □ Ask about patient’s preferences |
| □ N/A |
| Follow-up: | □ Clarifies plan □ Describes purpose of referrals and diagnostic tests □ Provides written information or plan (script or EMR) □ Assess patient’s level of understanding |
| □ N/A |
| Team Collaboration: | □ Introduces other members of team if present □ Describes roles of other team members □ Provides referral information to other professionals |
| □ N/A |
Declarations

The author has declared that there are no conflicts of interest.

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