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Medical Students' Views and Ideas About Palliative Care Communication Training

Elaine M. Wittenberg-Lyles, PhD, Joy Goldsmith, PhD, Sandra L. Ragan, PhD, and Sandra Sanchez-Reilly, MD

This study focused on the undergraduate medical student to identify views and ideas held toward palliative care communication training, pedagogical approaches to this training, and its perceived effectiveness and use in the medical field. Two focus groups consisting of fourth-year medical students were conducted, and their responses were analyzed using grounded theory categorization. Results indicated that students: (*a*) prefer to learn nonverbal communication techniques, (*b*) believe that natural ability and experience outweigh communication curriculum, (*c*) view the skill of breaking bad news as largely dependent on knowledge and expertise, and (*d*) prefer curriculum on palliative care and hospice to consist of information (eg, advance directives) rather than communication skills. Implications for these interpretive themes are discussed as well as future research and practice.

Keywords: palliative care; medical education; communication training

Emerging as a mainstream service in clinical settings across the United States, palliative care provides expert comfort care, particularly at the end of life, by prioritizing the patient's quality of life and emphasizing symptom and pain management, coordination of care, and patient and family communication. A majority of palliative care education efforts have focused on the development of end-of-life communication skills, documenting improved communication skills, increased confidence in communication, and improved self-rating of communication competence.[1-4] Overall, palliative care workshops, short courses, and interventions have been found to be effective and perceived to be valuable by graduates.[3-5] However, the improvement of communication skills has primarily resulted from palliative care education during residency rather than in undergraduate medical education.

Palliative care education has become one venue for introducing communication skills training in undergraduate medical education, with particular emphasis on how to break bad news to patients. Between 2000 and 2005, palliative care education in US medical schools increased from 87% to 94%, and 92% of schools claim that such curricula consists of instruction on communication with dying patients and communication with family members of dying patients.[6] The increase of palliative care training in this curricula came at the same time the American Association for Medical Colleges began requiring medical students to take a Clinical Skills Exam that includes an assessment of communication skills.[7] Consequently, undergraduate medical students receive communication skills curricula both inside and outside of palliative care coursework. This pedagogical separation of clinical education and communication skills training in undergraduate

From the Department of Communication Studies, University of North Texas, Denton, Texas (EMW-L); Department of Communication Studies Young Harris College, Young Harris, Georgia (JG); Department of Communication, The University of Oklahoma, Norman, Oklahoma (SLR); and University of Texas, San Antonio, Texas (SS-R).

Address correspondence to: Elaine M. Wittenberg-Lyles, Department of Communication Studies, University of North Texas, PO Box 305268, Denton, TX 76203; e-mail: lyles@unt.edu

medical education has contributed to the disparity in attitudes toward training among students.[8] As such, there is a need to investigate the pedagogical approaches to teaching communication skills in undergraduate medical education.[9]

The goal of this study is to explore attitudes and ideas toward palliative care communication training among a set of undergraduate medical students who participated in a fourth year elective course on geriatrics and palliative care. The purpose was to assemble students' opinions about the pedagogical approaches taken to teach communication skills in medical school. Given that the majority of communication training is obtained through coursework in palliative care, we also sought to ascertain these students' ideas and experiences in palliative and hospice care.

Attitudes Toward Communication Skills Learning

Research on communication skills learning in undergraduate medical education has revealed both positive and negative attitudes. Positive attitudes stressed the importance of communication in practice to be a "good doctor," the importance of such skills to a future career, an opportunity to improve skills, and the belief that learning communication skills was fun. However, negative attitudes revealed that students did not take communication skills learning seriously, as it was not considered a "pure science," coursework was taught by nonclinical lecturers, the timing of training was inappropriate, and communication was considered "nonacademic" and "common sense."[10]

Positive attitudes toward communication skills learning is significantly related to perceived importance of communication skills.[11] Compared to first-year medical students, fourth-year medical students have higher confidence scores about communicating with patients.[11] First-year medical students have higher positive attitudes toward medical communication training compared to second and third year students.[8] However, there is no difference between fourth-year medical students and first-year medical students on attitudes toward communication skills learning.[11]

Interestingly, positive attitudes toward communication skills learning become significantly lower by the end of the communication training course compared to the start of the course.[12] Prior research has noted that attitudes can become more negative as a result of teaching, with lecture-based teaching considered less effective than practice encounters and shadowing experienced physicians.[12,13] Additionally, positive attitudes may be related to problem-based and self-directed methods of learning.[12] Given the association between educational variables (eg, courses attended) and attitudes toward communication training, it has been suggested that attitudes toward communication skills learning may get worse over time.[8,12] Moreover, curriculum structure of communication training protocols may also affect students' attitudes toward communication-centered coursework.

A commonly used communication training protocol taught in US medical school curricula is the SPIKES protocol: an acronym for Setting, Perception, Invitation, Knowledge, Empathy, and Summary.[14] This protocol entails a script-based curriculum for teaching medical students how to deliver bad news (defined by these authors as medical news that is life-altering). According to the SPIKES protocol, *setting* guides the physician to create the best physical circumstances for conferencing with the patient; the details of the protocol even address proxemics, nonverbal leakage, and the presence of family in the conference space. *Perception* addresses the "ask before you tell" principle; physicians are to cull patients' understanding of their own medical situations. *Invitation* asks patients how much information they would like to have concerning their diagnosis/prognosis. *Knowledge* is the step in which physicians actually impart bad news. Alignment with the patient is encouraged in this step, as well as the use of nontechnical language in small units of meaning. *Empathy* follows the breaking of the bad news. Here the physician is encouraged to listen for and identify the emotions of the patient and identify the cause of those emotions—making a connection between the 2. The final element in the protocol is to summarize and develop a plan for the next step of care.

Although the SPIKES protocol provides a curriculum structure for teaching communication skills, scant empirical testing has determined its efficacy, and research on this communication training protocol has revealed contradictory conceptualizations.[15-18] Recently it has been argued that palliative care communication is a unique medical context that demands radically adaptive communication based on its acceptability to the patient and family.[15-18] Understanding the perceived cognitive and affective domains of communication in these settings, as self-reported by students, should lend insight into the

Table 1. Discussion Guide Questions: Views and Ideas About Palliative Care Communication Training

- What have your experiences been in palliative and hospice care?
- What are the differences between palliative and hospice care?
- Can anyone practice palliative care?
- For cancer diagnoses, is it the oncologist's job to break the bad news?
- ·What medical communication training might be useful to you in learning about palliative care?
- How can medical communication training influence your job?
- Will more communication training help you improve communication with your colleagues?
- Could communication training alleviate communication anxiety?

dichotomy between positive and negative attitudes toward communication skills learning among undergraduate medical students.[10]

Method

Design

Because medical students informally develop similar collective attitudes,[19] focus groups were used to obtain a purposive sampling of experiences, draw out unexpected issues from shared experiences, and allow the freedom for participants to validate and therefore elaborate on their experiences and ideas.[20] The focus group, previous to 1980, was thought to be a preliminary gathering tool en route to a larger, more credible method and data set; now the focus group is well understood to be a highly complex, time consuming, credible, rigorous exploratory tool of the human experience.[21] Interaction among group members about their pedagogical analyses could not be captured without the use of a directed focus group discussion.[22] Discussions with several in a group create a cascade of ideas or a chaining effect. Real talk moves ideas forward as the group reveals their own norms as participants in their setting.[22] Table 1 shows the discussion guide questions used in this study.

Setting

After receiving approval from the Institutional Review Board, this study was conducted at an urban medical school in a large city in the south-central region of the United States. The institution has roughly 830 active students, with nearly 210 in their fourth year of instruction. Of this number, 24 fourth-year students enrolled in an 8-hour geriatric palliative care medicine elective. The elective course was taught by a geriatrician with formal training and expertise in palliative care. In general, students at this institution do not receive dedicated coursework on communication skills training; instead these skills are taught within larger core courses such as medical interviewing, resulting in exposure to several lectures on the SPIKES protocol.

Participant Recruitment

Students were recruited to participate in this study from the geriatric palliative care elective course roster. On the first day of class, the research team approached students about the study and asked them to participate. Students were assured that if they elected not to participate, their status in the course would not be affected nor would their academic standing be affected in any way. In March, 2007, 2 focus groups with 8 and 10 participants, respectively, were conducted on the first day of the elective course. Table 2 displays participant demographic data. The elective course was offered in late March of the fourth year of medical school and thus students had already conferred their chosen specialty.

Focus Group Procedures

The research team consisted of 3 palliative care communication scholars and the Palliative Care Fellowship Program Director. One of our researchers (EMW-L) served as the moderator in one of the focus group sessions, while the Program Director (SSR) moderated the second session. Both focus groups met during the scheduled elective course meeting time in a classroom (60 minutes). Only focus group participants and members of the research team were present. Informed consent was obtained from all participants when they arrived for the first day of class.

Researchers built a moderator's discussion guide to ensure consistency in distinct issues for discussion between the 2 focus groups. Primarily, this guide served as a memory aid and agent of focus for the 2 moderators. Specifically, the discussion guide was designed to (*a*) elicit student experiences with

Table 2. Characteristics of Fourth-Year Medical Students Who Participated in 2 Focus Groups (n = 18)

Characteristics	Value
Age, in years	
Mean (range)	27 (25-34)
Gender, n (%)	
Male	8 (44.4%)
Female	10 (55.6%)
Ethnicity, n (%)	
Hispanic	3 (16.7%)
Pacific-Islander	1 (5.6%)
Caucasian	7 (38.9%)
Asian	7 (38.9%)
Medical specialty	
Cardiology	1 (5.6%)
Oncology	1 (5.6%)
Psychiatry	1 (5.6%)
Radiology	1 (5.6%)
Anesthesiology	4 (22.2%)
Surgery	2 (11.1%)
Internal medicine	8 (44.4%)

palliative and hospice care and elderly patients, (*b*) reveal existing knowledge about palliative care in clinical settings, (*c*) determine previous medical communication training at their institution and its applicability to end of life, (*d*) obtain attitudes about medical communication training and opinions about using communication to build relationships with patients, (*e*) generate ideas about how medical communication training can affect the role of the physician in communication with patients and staff, and (*f*) reveal student preparation in breaking bad news in a palliative care setting.

Two additional research team members, both trained in communication, observed and took notes during the focus group sessions. By using multiple researchers in each focus group, we could also note observations during the group discussions. Our team composition enabled us to take advantage of our distinct overlapping competencies. Lindlof and Taylor advocate for multiple researchers in qualitative studies, noting that misaligned observations ultimately contribute to the richest description of real-time communication events.[23]

Data Analysis

Both discussions were audio-recorded and transcribed in total. Two sets of observational notes were recorded during each focus group session as well to produce multiple methods or perspectives of the data, a process called triangulation.[24] The transcripts were analyzed among the first 3 authors using an iterative process of theme analysis composed of 4 distinct grounded theory phases.[25,26] Qualitative data software was not used. Stage 1 included *open coding* in which we identified unrestricted chunks of texts that suggest a theme. At this point in the process, interpretations are tentative and categories and their linkages to other themes are not addressed. Phase 2 involves *integration* in which previously identified themes are connected, collapsed, or associated. In phase 3, we finally clarify the *categorization* of information units (talk), enabling us to move into phase 4 in which we construct interpretive claims about the categories identified in the group discussion.[23,26] This process was conducted separately for both groups until data saturation was reached and data were then coded across both groups.[20]

To establish validity, the first 3 authors analyzed the data independently—all of whom are academically trained and published in grounded theory as well as focus group methodology.

The authors then met to identify and integrate themes that had been independently identified. Through discussion, themes were sorted into categories by identifying commonalities and differences. Thematic categories emerged through the process of constant comparison by combining and organizing subcategories into a smaller number of categories.[27] Once small categories were created, the authors reviewed the transcripts once again and themes were developed and refined through this process. The meaningfulness of the process was evaluated by the fourth author who examined the categorization of the data. Finally, all 4 researchers determined interpretive claims. Observational notes were used to follow the research process, creating an audit trail of the interpretative claims derived from the transcript data.[23]

Results

Four themes about student views and ideas emerged as a result of the 2 focus group discussions. First, students voiced recognition of a dichotomy between script training and nonverbal communication curriculum, preferring to learn quick, simple steps that could be easily integrated into their own communication style. Similarly, experience and a natural ability

to communicate were considered by students to be more important than learning about communication theory. Third, students believed that knowledge and expertise were quintessential to breaking bad news, explaining that lectures were not sufficient curriculum for teaching these skills, and in the case of communicating, a terminal diagnosis many questioned whether they were the responsible party for such disclosures. Finally, most students had adequate knowledge of palliative care and preferred curriculum on end-of-life care information (eg, advance directives) rather than learning communication skills. The following sections elaborate on each theme.

Scripted Versus Nonverbal Communication Training

Attitudes expressed by our participants indicate miscommunication and/or ambiguity about what constitutes medical communication training. Specifically, students (S) were clear in their views about communication training that consisted of a formula (eg, a script) versus communication training that mostly addressed nonverbal communication techniques, with favorable attitudes toward the latter:

(S) But there are simple things, like I was surprised. It was interesting to learn that if you sit down they'll take it better. If you get down to eye level then a patient perceives that you've spent more time there and those are things that may be obvious but not for a rushed medical personnel so I think that type of skill I think can affect your relationship and not be too, I mean it can be very mechanical.

The reference here to the "mechanics" of communication might illustrate a lack of ease experienced while performing medical communication altogether. Rather, his argument assumes that individuals inherently know how to perform good communication and that the effectiveness that can be obtained by skills training is not in *what* to say but rather in *how* to say it. Other students agreed, arguing that "little tools" about *how* to communicate would be helpful and attitudes were favorable toward learning these tools.

(S) I guess there's little things that we've learned like we're not suppose to stand above patients and hover over the patient, we should try to get at the level where they are, so little tools like that are helpful (.) otherwise you can't teach it.

As part of these "little tools," participants explicitly desired that communication skills training include the development of practical content knowledge, particularly in regard to end-of-life conversations.

Experience and "Natural Ability" Outweigh Theory

In addition to the content of communication skills training in medical undergraduate curriculum, student attitudes reflected favorability toward experience versus lecture format. One participant concluded, "If you're a good communicator, then you communicate well in all contexts, so you don't need specialized training." In general, the participants concluded that communication skills are absorbed; this takes place before you get to medical school. Actual new medical skill acquisition occurs in practice alone. Another participant explained, "I mean we could sit through hours and hours of lecture, but 5 minutes with a patient, we learn more."

The value of these "learning by doing" pedagogical approaches was considered overwhelmingly more important.

(S1) I just feel that the actual experience makes you learn more about what you are saying ... learning about it is one thing but application is a totally separate thing.

(Facilitator) Can you be taught communication skills that will influence/help you build relationships with your patients?

(S) Some of that you have to have before you get here.

(S2) I agree.

(S3) You have to experience it. You have to have patients, like real patients, like patients of different cultures or don't speak the language, or young patients .... I almost feel like a lot of communication can't be taught it needs to be experienced.

Role modeling was preferred to all other pedagogical approaches. Participants articulated that both good and bad role modeling was beneficial in their own development of good communication practice.

(S) The best way is to be with an attending and watch them break bad news to a patient about dying and talk to the family and then talk to the attending afterwards about it. I had that experience just a couple of times in third year and that had a much bigger impact and I was able to recall that much better ....

(S) [I think we should] have our attending physicians, who are really good at breaking bad news, like go in and do it, like everything that they would

usually do, and then you can learn how it is that they do it.

(S) I think we could also learn from poor attendings. I had an attending who broke bad news that this little girl was terminal and we had done all the radiation and all the everything we could do, all the chemotherapy and she said and this is Kelly, she's going to be a psychiatrist and she'll just sit here and just left the room. And I was like I don't know anything. And so I think we can learn from those attendings also on what not to do.

Likewise, participants also felt that even poor role modeling could prove to be beneficial in learning more about communication with patients.

Breaking Bad News and Terminal Diagnosis

The proliferation of the SPIKES model and its incorporation into student curricula was evident in the discussion of breaking bad news. However, the lecture and components of the protocol itself seem to present limited use to students as described in their own words.

(S) We've had in like 10 different classes, in psychiatry, psychology, we've had it [SPIKES] in survey classes with medicine, so we've had that a lot.

(Facilitator) And it is breaking bad news in terms of a terminal diagnosis or in terms of any bad news?

(S) In terms of any bad news.

(Facilitator) Well, there's bad news in terms of terminal diagnosis, what would be the other types of bad news?

(S) Any kind. And we've heard it so many times but we've never gotten to really practice it. So I feel like hearing it it's just kind of like.

(Facilitator) Redundant?

(S) You kind of zone it out because you've heard it so many times.

The desire to put protocol into practice was further described by a student who experienced sharing chronic/terminal bad news with a patient and benefited enormously from being able to view her own communication in action. This student also notes her profound frustration with the timing of this experience, only 5 weeks prior to graduating:

(S) We had this guy with this lung mass, and we had to explain to him what we saw and they videotaped it so it was on DVD and it was a 15-minute encounter and you had the opportunity to go back and watch your own video and we could see did we follow those rules [SPIKES]. Did we sit at eye level? Did we you know sit closer to the patient and stuff like that and I thought that that was you know actually the first time that I got to practice these skills that I've read about, read about, read about, and thought that I should do fine, but then you know once you sit down and watch yourself you're like "oh my goodness."

(Facilitator) So you thought that was beneficial?

(S) I thought that was beneficial and it wasn't until last week that I got the opportunity to do that.

Lecture-based communication skills training suggesting a linear approach to communication inherently implies that physicians can and will prepare to deliver bad news. However, 1 female student describes that this approach is not always applicable and thus the lecture training was not useful:

(S) I think it depends on what field you're in, I'm gonna be an OBGYN and a lot of the bad news that I've dealt with currently it's not something you have to prepare for. Let's say you're doing an ultrasound and you find something very wrong, you don't have time to prepare what you are gonna say, you have to show them right then and there, your baby isn't perfect, this is what's wrong with your baby, this is what's probably gonna happen. You don't have time to think up what you're gonna say ahead of time, you just have to do it in real time.

Most students agreed that the time needed to plan bad news was one reason they did not value communication skills lectures. The overwhelming majority preferred hands-on communication training, arguing that "theory doesn't convey what communication is really like with patients" and as 1 female student concluded, "you kind of learn all along."

In consonance with the SPIKES protocol's implication of preparation and planning, the model and its designer overtly claim its use in the realm of decreasing physician anxiety in the moment of sharing bad news.[14] This student, though not exhausted from the work of years in the field, describes what is, in essence, unnatural about leaving anxiety behind in communication about death. Including anxiety as a component of a bad news communication addresses the human cost for all interlocutors—something the protocol might encourage students to deny.

(S) I think you should always feel anxious. I mean you have to give someone bad news. If you're being empathic for them then you feel a little bit of what they feel. I don't think that any amount of training

should make that go away. You should always feel for your patients. I wouldn't want to be NOT anxious about their outcomes.

Another student described anxious feelings in yet another way:

(S) I think it would decrease it to a point say if you are really anxious you might go in and you're like you gotta break this bad news and then you get in there and you know you don't want to break it all the way, I mean like leave us a little bit of light at the end of the tunnel for them and that's not what you wanted to do but you did that because you were so anxious and you felt real bad or whatever but if you had pretty good communication skills you could go in there and deliver the news that you actually wanted to deliver it.

This student's comment about preparation and anxiety is representative of research, uncovering a reality among physicians treating chronically or terminally ill patients. Physicians who do not address their anxiety and emotion about chronic/terminal communication are more likely to overprescribe costly, time-consuming, and ineffectual treatments and abandon patients and their families.[28] As 1 student described, the avoidance and anxiety about death is something we come by honestly in American culture.

(S) I think it depends on the practitioner too. Some people feel uncomfortable talking about sex, they feel very uncomfortable, so if you just started using words that you may not have been allowed to use in the past like death or religion or whatever the subject. It would depend on the individual's comfort level. So I think training could make a difference in a physician who was had never thought of about or talked about death. I mean, I think that would be an uncommon thing for most people because that's how our society is.

There was much discussion among the participants about who was responsible for breaking bad news. Overwhelmingly students voiced the general belief that the physician is "in-charge" of these interactions, and 1 male student explained that this was particularly necessary when the physician and patient had a clinical history:

(S) I think it depends on the rapport that you have with the patient as well because if this is a patient that you have been taking care of for the last 20 years, I think it's your responsibility to tell the patient. Why would you send them to someone else to tell them the news? So, I mean maybe it's their first visit or something like that I could see ... but I think if you're a doctor who cares I think it's your responsibility.

Similarly, other students commented on the importance of being responsible for disclosing bad news to patients, while at the same time emphasizing mindfulness of the time spent communicating with patients about these matters.

(S) You just try to be nice yeah, you know. How ya doing? This is what we gotta do. Now would be the time to spend about an hour talking about their head spinning. We've got to prioritize our time, you know do it, and move on, but you know try to do it in a respectful manner.

Overall, knowledge and expertise were considered fundamental elements in a physician's ability to proficiently communicate bad news with patients and families. Interestingly, many students voiced a desire for oncologists to deliver bad news regarding a terminal cancer prognosis (only 1 oncologist was present among all participants). When a facilitator sought clarification on this issue, several students believed that expertise was the determining factor in the delivery of bad news to patients:

(Facilitator) For cancer diagnoses, is it oncology's job to break the bad news?

(S1) Yeah, it seems like ... they're making the diagnosis, they're the experts.

(S2) Because they're going to provide the treatment if there is any.

(S3) Alternatives that they might know of that the primary team has not necessarily heard of yet, so yeah.

Having a solid understanding of the biological processes of disease and illness was believed to be positively related to the physician's ability to effectively communicate with patients and families. Although oncologists were believed to be the best professionals to deliver terminal cancer prognoses, participants in this study felt that all health care practitioners had some amount of responsibility when communicating bad news. The responsibility, however, was not to deliver the bad news but to reiterate the message:

(S) It's actually everyone's role and you have to tell them and the nurse would go up later and re-explain what happened and the next team would go in and explain it and every time the shock wears off the more they will comprehend death or the cancer word.

Some students described the gap that can develop between medical parties when communication about dying is not expressed in consonance by practitioners. Participants recognized the immense

difficulties produced by mixing messages for patients/families, as revealed in this exchange.

(S) I mean sometimes the patient's family would know more than the patient because those people are actually calling and you know you can talk to them. But as far as the patient like um ... especially if they are being seen by multiple teams so like oncology will tell them "oh yeah there's tons of stuff we can do" and um I'm like they're terminal but you still have to go in. So every morning you go in and the family's there and you're like "he's not gonna make it," not in those terms, and then in the afternoon oncology says "oh yeah there's something we can do" and then the next morning they are talking about miracles and stuff.

(S1) I think the oncology team should break the bad news.

(S) Well I just figured they would, but they weren't. They were just talking about treatment. I mean that's what they do.

Students articulated the recognition that the pattern of resisting open communication is both real and damaging in the hospital setting.

Ideas and Experiences with Palliative Care and Hospice

Participants clearly wanted information about end-of-life care more than communication skills (eg, does the wife's or the children's will prevail over end-of-life decisions if there is no advance directive?). Most often their ideas and stories centered on the end-of-life segment of palliative care. They articulated a desire to possess a further understanding of legal issues about advance directives, services provided by interdisciplinary team members, and role clarification of team members.

(S) I had an interest in end-of-life care since I was in London doing pain research and it was interesting to learn that in the U.S. pediatric palliative care is ... if you can get some people to acknowledge that end-of-life care, you have your 85 year old person then it should be there. But if it turns into a 12 year old person then they want them on machines forever and so that attitude is not international and so it's a U.S. thing for sure. Um it was also interesting to see that I learned that children with disease, I don't know like pediatrics is where I learned it, mature so quickly.

"Calling a consult" occurs when a physician requests a palliative care consultation (interdisciplinary team) enter into a patient's care. Here a student describes the phenomenon that occurs when a consult is *not* called—or if it is called yet a patient does not receive this consult care until the very end of life.

(S) I was thinking that's one of the barriers to call a consult. I think that I've seen individual physicians feel that the attitude that it would be giving up or that it would be something that they could do and even though there's a field dedicated to the study of it um some people try to accomplish these goals on their own and the expectation is not the end result when people are not open to doing that. I think education at an earlier stage.

Medical students did express a basic understanding of palliative care, explaining that key elements included pain management, advance directives, talking with family, and requesting consults. While students agreed that palliative care was for all patients and family members, there was disagreement over who could provide palliative care, with the majority of students arguing that any health care practitioner could provide palliative care.

Descriptions of their clinical experiences with palliative care and hospice and subsequent views revealed a lack of familiarity with the concept of palliative care and/or hospice. One female student concluded that experiencing death and dying during her clinical rotations was not pleasant, as compared to her time spent as a hospice volunteer. Other students described patient cases as "depressing situations," and 1 male student described hospice as "a waiting station for death that I wouldn't want anyone in my family to go through." Another male student explained that "the patients never know ... they don't really know what's going on." The majority of participants in each group reported that they were not exposed to enough death and dying experiences.

Discussion

Resonating with earlier findings on attitudes toward communication training,[10] students felt negatively toward communication training that consisted of application of a routine script, claiming that the communication formulas seemed contrived and artificial. The pedagogical redundancy of communication protocols as embedded within several courses without adequate time to practice them was not considered useful. In both groups, there was a general sense that communication training had been time-

consuming and without applicable purpose. Given that students were more interested in learning about *how* to convey certain messages rather than *what* messages to provide clarifies student views about the role and function of communication and consequently the development of communication skills. Namely, the popular views and ideas expressed in this study portrayed the belief that individuals should inherently know what messages are appropriate and that communication skill development could be beneficial in learning *how* to convey those messages. However, prior research has found that knowing how to communicate effectively is quite different than being able to communicate effectively when working with seriously ill patients.[29]

Student preference and favorable views toward real-time experiences over communication lectures demonstrate 1 reason why students have less than favorable views toward communication skills training. This is an important finding given that 87% of death and dying undergraduate curricula are delivered in a lecture format.[6] Dissatisfaction with lecture formats, and student desire for tools rather than prescriptive communicative scripts, suggests that pedagogical approaches to palliative communication training need to involve interactive approaches that highlight specific verbal and nonverbal strategies.

Role modeling, defined as learning that is facilitated by observation of teachers modeling patient-centered behaviors in clinical work,[30] as well as practicing the delivery of bad news with standardized patients, was deemed more desirable than lectures. While students voiced obvious support for role modeling, comments shared overall in the focus groups demonstrated a discrepancy in what students perceived as beneficial learning experiences and what actually occurs in the role modeling process. Participants articulated that role modeling was beneficial when the resident/attending physician talked with the student about their own communication approaches. However, there are 2 inherent problems with role modeling as a main pedagogical approach.

First, there is not enough time for the resident/attending physician to talk with the student about the event. A male student commented: "Yeah, but it just doesn't happen very much here. There's just never enough time to do it." Busy rotation schedules and other pedagogical elements of role modeling are primary learning points, and often communication elements of role modeling are neglected. For example, students in a recent study, who aimed to develop interprofessional skills, reported poor communication between the various parties involved, and only 2% reported the development of patient and interpersonal skills.[31]

Second, participants commented that they did not receive enough role modeling opportunities during their medical education. Not surprisingly, some participants commented that the residents and attending physicians that they worked with were not comfortable talking about death. Rather, these practitioners looked for hospice professionals or someone else to talk to patients about dying. These conclusions about role modeling are problematic given that medical students from 9 US medical schools reported that they observed role modeling 61.7% of the time in medical school, and thus, not every student has a role modeling experience.[30] While students believe they are learning communication skills in this fashion, our study suggests that observational learning does not adequately take place if it is not combined with evaluation of the observed interactions.

For these medical students, time appeared to be a primary concern. Students are heavy laden with medical educational requirements that "outweigh" what is thought to be simplistic, ascientific, communication training. This coincides with our previous discussion about preconceived notions of communication training. Students see little value in learning or devoting time to something that should be innate or predisposed. In addition, the amount of actual practice or observation time is extremely limited. Medical students are at the mercy of the attending physician and if time is not spent reviewing or explaining various communication encounters, than there is little headway made besides mere observation. Second, expertise and knowledge are believed to be the primary indicators of effective communication with patients. This leaves little room for skills; in other words, if you are knowledgeable in what you are presenting to the patient, then you are communicating "effectively." These findings suggest that current protocols emphasize information exchange in medical encounters and neglect the practice of relational support, which is unique to palliative care communication.[17] Consequently, students' views about communication competence are narrowed by attention to the singular goal of imparting medical information within the medical encounter. The time necessary to learn and practice this skill is therefore considered minimal, leaving little room for the

development of relational communication skills necessary in palliative care.

Contributions to Researchers and Practitioners

This study provides information about medical students' views and ideas about palliative care communication skills training and their pedagogical preferences for learning about communication practices in medical contexts. Given that this study explores only 2 focus groups of fourth-year medical students, it is not our purpose to extrapolate these interpretive themes to all medical students at any point in their undergraduate education. This work does, however, indicate that further inquiry and action be taken on the subject of palliative care communication skills training.

There is an overall disconnect between what our participants prefer and value in medical communication training and current curricula and structure. The findings of this study outline several areas of consideration for medical education curricula. First, the overall definition of communication training needs to be restructured. There needs to be a shift from identifying innate communication disposition to the acknowledgment of learned communication skill. Second, a shift needs to take place from learning nonverbal techniques to communicative strategies that can be applied to practical situations. For example, recent research on palliative care communication has identified the importance of redundancy when breaking news of a terminal illness/diagnosis as well as the pivotal role of communicating with family.[18] Third, communication scripts, particularly for use in breaking bad news, need to adequately represent the complex communicative challenges that arise in the chronic/terminal context. Medical communication curricula need to inform students about the arsenal of communication tools that can be adapted, adjusted, and applied relative to the challenges of the interaction. Interestingly, many students were frustrated by what they viewed as an excess of lecture training during their education—noting that communication is something you do well or do not do well. Concomitantly, the same groups of students readily noted communication training needs that were outstanding, including talking to families and breaking bad news about terminal diagnosis. Current training and its deficits are plainly evident from these students' dichotomous positions.

It has been noted that the development of communication skills is one of the main resources needed for mainstreaming palliative care.[32] However, participants in this study revealed that students' pedagogical and curricular communication training needs are not being met in palliative care undergraduate education. Rather, participants shared a need for real-time experience rather than classroom lecture. Allowing the student to participate in or at least watch and discuss communication practices with an attending physician will satisfy the needs that so many medical students appear to desire. Medical communication training should incorporate formal evaluation of real-time role modeling, an endeavor that first requires faculty development in teaching and assessing communication skills.[33]

Finally, an intrinsic tie to these ideas about communication is the assumption that communication is goal-directed, an idea that is not currently addressed in current training. The integration of goal assessment in medical encounters could prove to be beneficial in developing specific pedagogy in this area. For example, in teaching empathy and empathetic communicative strategies, students must first recognize and accept empathy as an achievable and desirable goal in the interaction. Including a discussion and exploration of the students' desired goals in medical interactions as part of training curriculum could highlight specific communicative techniques to achieve these goals. In this manner, faculty could acknowledge the implied understanding that communication is a known, inherent skill, yet still highlight the varying levels of goal attainment. These goals may include tangible behavior that constitutes relationships, an important aspect of palliative care communication.[34]

It is possible that these ideas and concerns can be used as pedagogical motivators for undergraduate medical students. By juxtaposing a discussion of the physician's role and responsibility in bad news disclosures, for example, key communication skills can be implemented to ensure effective delivery in a timely fashion, thus meeting 2 of the goals that students have prior to the introduction of communication training curricula. Undergraduate medical students might be more open to learning communication skills if they are offered as a skill set that will optimize their efficiency in these interactions.

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