AGENŢIA ROMÂNĂ DE ASIGURARE A CALITĂŢII ÎN ÎNVĂŢĂMÂNTUL SUPERIOR
*Membră în Asociația Europeană pentru Asigurarea Calității în Învățământul Superior – **ENQA***
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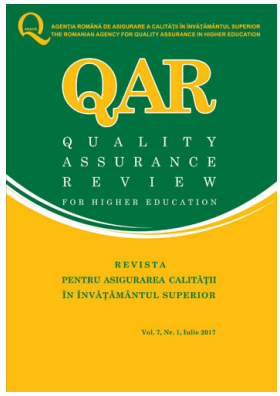

Quality Assurance Review for Higher Education

New Perspectives on Quality Assurance in Medical Education. Developing Essential Clinical Skills

Daniela-Luminiţa Barz, Radu Oprean

Quality Assurance Review for Higher Education, Vol. 7, No. 1, 2017, pp. 25 – 35

Publicat de: Agenţia Română de Asigurare a Calităţii în Învăţământul Superior - ARACIS
Locul publicării: Bucureşti, România
Tipul publicaţiei: tipărit, online
ISSN: 2066 - 9119, 2069 - 2188 (online)
Adresa: Bd. Mărăşti, nr. 59, Sector 1, Bucureşti, cod poştal 011464
Telefon: +40 21 206 76 00; Fax: +40 21 312 71 35
E-mail: qar@aracis.ro
Pagină electronică: http://www.aracis.ro/en/publicatii/qar-magazine/numarul-curent/

Revista *Quality Assurance Review for Higher Education* este editată din fondurile proprii ale ARACIS şi, în această etapă, contribuie şi la sustenabilitatea proiectului „Dezvoltarea şi consolidarea culturii calităţii la nivelul sistemului de învăţământ superior românesc - QUALITAS”, Contract POSDRU/155/1.2/S/141894.

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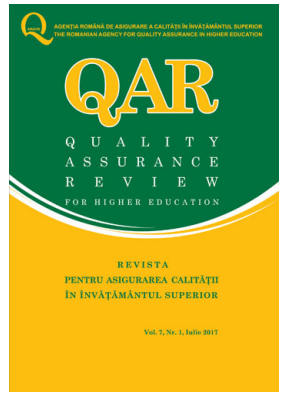

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Published by: The Romanian Agency for Quality Assurance in Higher Education - ARACIS
Place of publication: Bucharest, Romania
Publication type: printed, online
ISSN: 2066 - 9119, 2069 - 2188 (online)
Address: Bd. Mărăști, no. 59, sector 1, Bucharest, Romania, postal code 011464
Phone: +40 21 206 76 00; Fax: +40 21 312 71 35
E-mail: qar@aracis.ro
Web page: http://www.aracis.ro/en/publications/qar-magazine/current-issue/

Quality Assurance Review for Higher Education is edited from ARACIS own funds and, at this stage, also contributes to the sustainability of the project "The development and the consolidation of quality culture at Romanian higher education system – QUALITAS", POSDRU Agreement 155/1.2/S/141894.

New Perspectives on Quality Assurance in Medical Education. Developing Essential Clinical Skills

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Abstract: *Current issues in medical education involve ensuring the quality of training methods in developing essential clinical skills within a framework of two contrasting paradigms: Evidence-based Medicine (EBM) and Personalized Medicine or Person-Centered Medicine (PM). Quality assurance in medical education represents a broad range of activities, under which both meeting the requirements of the external standards and enhancing the quality of teaching and learning at an institution are included. The current article focuses on new perspectives regarding maintaining and enhancing the quality of medical education, with special attention given to the development of doctor-patient communication skills throughout clinical training. Research has stressed the importance of integrating communication skills training into the postgraduate curriculum and offered complex simulation scenarios and interdisciplinary teamwork as the greatest opportunities for learning and quality improvement.*

Key words: *medical education, residency, doctor-patient communication, curriculum*

Rezumat: *Provocările actuale în educația medicală implică asigurarea calității metodelor de formare pentru dezvoltarea aptitudinilor clinice esențiale în contextul celor două paradigme predominante: Medicina Bazată pe Evidențe (MBE) și Medicina Personalizată sau centrată pe persoană (PM). Asigurarea calității în învățământul medical reprezintă o gamă largă de activități, din care fac parte atât îndeplinirea cerințelor standardelor externe, cât și creșterea calității predării și învățării la o instituție. Articolul de față se concentrează pe noi perspective în menținerea și îmbunătățirea calității învățământului medical, cu o atenție specială*

acordată dezvoltării abilităților de comunicare medic-pacient pe parcursul practicii clinice. Cercetările în domeniu au subliniat importanța integrării formării abilităților de comunicare la nivel postuniversitar, practica bazată pe scenarii complexe de simulare și muncă în echipe interdisciplinare fiind considerate cele mai eficiente metode de învățare.

Cuvinte cheie: *educație medicală, rezidențiat, comunicarea medic-pacient, curriculum*

Motto: "...a huge part of our education here is to learn how to be compassionate and supportive of patients. Yes, for some of my classmates this is a difficult lesson but we are all learning. We are striving to become better people, better doctors, better friends. We take classes on ethics, write essays on what kind of doctor we want to be and how we think a doctor should act, and spend time with patients who have chronic illnesses at their homes, learning what life is like as a patient and how we can be better doctors by getting to know them as a person. All physicians can learn to be compassionate since isn't that why we went into medicine in the first place?" [1]

— Dejah, 1st year Medical Student at Penn State College of Medicine, USA

Introduction

EBM has been defined as "the conscientious, explicit, and judicious use of the best evidence in making decisions about the care of individual patients" (Sackett et al., 1996). Key components of EBM include Information Mastery (IM), the skill of searching efficiently amongst medical research, Critical Appraisal (CA) of medical research and Knowledge Translation (KT), which entails applying the best evidence in a clinical setting. Although EBM has been around for centuries, the focus on using the best evidence in medical research to treat patients began in the late 1980s in Canada and United Kingdom (Mayer, 2010, p.11). The first component of EBM is Information Mastery (IM), (Mayer, 2010, p.10). Therefore, to be able to follow this sequence of EBM, a physician must be able to search within a reputable database, to be able to understand research methodology, interpret data and assess clinical cases using complex scientific reasoning. Although based on EBM principles, medical education should focus on developing research skills, comprehensive research and academic evaluations indicate a strenuous need "to re-introduce humanistic ideals into clinical practice alongside continuing scientific advance" (Miles, Asbridge & Caballero, 2015). However, a person-centered approach to medicine can only be fostered through person-centered education and training.

Effective doctor-patient communication represents an integral part of healthcare services. Research has stressed the importance of integrating communication

[1] Quote retrieved following comments regarding article "Can bedside manner be taught" by Tara-Parker Pope

skills training into the postgraduate curriculum, which should continue during the clinical training. However, defining and classifying clinical indicators for quality improvement has proven to be a difficult and complex task. Quality standards and performance indicators regarding specific components of medical education are still debated.

The lack of training in communication skills has been identified as one of the main issues to be addressed. Although most universities have included courses on medical psychology and the bases of medical communication into their curriculum, insufficient support has been given for practical skills' development. All stakeholders acknowledge the importance of a good doctor-patient relationship, but also admit that it's the one thing neglected throughout the educational process. However, professors have stated that the growing number of trainees has made this a burdensome goal to reach, the number of residents per patient is too high for an optimal clinical setting. This is just one of the multiple facets of doctor-patient communication training.

The Benefits of Effective Doctor-Patient Communication

The importance of a good doctor-patient communication has increased due to widespread access to health information through media outlets. Internet has had a massive impact on the public's expectations regarding the amount of information received during medical consultations. In the past, doctors were the main source of information for all health-related information; during the past years, we seem to have witnessed a shift in paradigm — patients require more information on the symptoms they're experiencing, causes for their health issues and treatment options. Google has become "the new diagnostic tool" for much of the population, which apart from its informative value, also has repercussions on the doctor-patient relationship. Now, with the increasingly popular WebMD Symptom Checker patients can receive a diagnostic, print out an entire doctor's report and access all information about treatment, based on their symptoms. Thus, one of the main consequences of widespread access to health information refers to the change in patients' expectations and the irrefutable need for effective doctor-patient communication.

Research has gathered overwhelming evidence for positive consequences of effective doctor-patient communication. Improved doctor-patient communication has been associated with higher compliance with medical treatment, better health, functional and emotional status, higher clinician and patient satisfaction, and reduced medical malpractice risk (Shukla, Yadav and Kastury, 2010, 208-209). The Eurobarometer Qualitative Study on patient involvement has analysed the issue of patient-practitioner relationship in terms of trust, equality, power, support and control (TNS Qual+, 2012). Findings suggest that good communication increases patients' trust in practitioners, which, in turn, enhances treatment adherence and the recovery process. Insufficient information and discussion about diagnoses and

treatments was linked to a sense of powerlessness. Results of the survey showed that patients feel more in control when they can ask questions, are listen to and are given choices, which is beneficial to their health. Although patients acknowledge doctors' expertise and knowledge, more and more of them want to be given additional information and have a role in decision-making.

These results are supported by studies on the essential role that information gathering through in-depth interviews plays in the diagnostic process. Studies have demonstrated that after attending communication skills training courses, medical trainees were more capable of detecting and responding to behavioral cues and improved their diagnostic skills (Evans et al., 1991, apud WHO, 1993, 1; Aspegren, 1999, 4). Also, research has shown that medical trainees who did not attend communication skills courses declined in their patient interviewing performance throughout their clinical training (Bishop et al., 1981, apud Aspegren, 1999, 4).

Another term for doctor-patient communication, dating back as far as 1869, mostly used in the United States of America, has been 'bedside manner'. The analysis of bedside manner of the clinical personnel revealed there were specific behaviors that were perceived by the patients as positive or negative during doctor-patient interactions. Positive behaviors included respectful discourse, active listening, while negative behaviors included an arrogant, superior discourse and disrespectful language (Person and Finch, 2009, 1-2). Even though the concept hasn't been given proper attention in the literature, studies have demonstrated that doctors who were considered good listeners had the best relationships with their patients and the least amount of negative feedback (Tamblyn et al., 2007, 993-1001, apud Person and Finch, 2009, 3). Body language has also been included in the assessment of bedside manner. Doctor's appearance, making eye contact, position of the body and the tone of his voice have been found to influence patients perception of bedside manner and ultimately, their well-being (Bendapudi et al., 2006, Frankel et al., 2006, apud Person and Finch, 2009, 3).

From a practical perspective, the benefits of making communication an essential component of health sciences curricula were also proven to be cost-effective. With this shift in patients' expectations, communication skills seem to make the difference between highly-rated doctors and poorly-rated doctors. In the private sector, poor communication leads to patient dissatisfaction, which subsequently, means profit loss. Improving the quality of health services through communication training should be implemented in core healthcare curriculum. Integrating new clinical indicators, such as doctor-patient communication, into quality assurance policies can result in multiple institutional gains. Through interdisciplinary efforts to improve communication courses, universities can raise the quality of teaching and educational methods by shifting the focus toward learner-centered teaching methods and enhancing both academic performance, as well as clinical performance (WHO, 1993, 3).

Integrating Communication into the Curriculum

Based on the growing body of evidence, medical education governing bodies have recognized clinical communication as an essential component of postgraduate education (Laidlaw and Hart, 2011). Patient-centred interaction has become an acknowledged learning outcome for many medical curricula. However, there are several key points which should be considered when integrating effective communication courses into the curriculum. Patient-practitioner relationship has become a relevant issue in the context of the patient-centered model. Developed over the past decades, the patient-centered model integrates the conventional understanding of illness (medical model) with the patient's subjective experience. The medical model was focused on the doctor's control over patient outcomes, while with the patient-centered model, the patient gained control over his condition and the doctor must be able to empower the patient, in a collaborative relationship. The patient-centered model consisted of six interrelated components, which were formulated as recommendations, in response to cues received from the patient. The first component referred to the exploration of both the clinical aspects of the disease as well as the patient subjective experience of the disease, which would lead to better understanding of the patient as a whole person. The patient-centered model implied a shared decision-making process and so the third component referred to efforts directed at finding common ground regarding the management of the disease. These recommendations focus on incorporating prevention and health promotion, while enhancing the doctor-patient relationship and developing the doctor's personal communication skills.

The communication curricula must build on the patient-centered framework and the implementation should focus on teaching residents and specialists the integrated approach to clinical practice. The goal of such a curriculum would be to develop "a commitment to partnership and the concept of patient autonomy which puts patient choices and self-determined needs at the core of health care interactions" (von Fragstein et al., 2008, 1103).

Research and health education governing bodies have mapped out the major key-points that a doctor-patient communication curricula should contain (Haq et al., 2004, 44-49; von Fragstein et al., 2008, 1103-1104; Laidlaw and Hart, 2011, 6-8). Recommendations regarding design, implementation and review of communication curriculum have included general supporting principles, which should be used as guiding framework in all areas of medical practice. The most important supporting principles which have been identified as vital components throughout curriculum design have been a focus on reflective practice, developing professionalism, ensuring ethics awareness and an evidence-based practice approach. Reflective practice referred to personal self-awareness, metacognition and dealing with uncertainty, whether it's related to case management or patient care. Professionalism was

considered the attribute which should characterize every physician's activity; it was thought to incorporate integrity, honesty and to facilitate the understanding of doctor-patient relationship boundaries. These boundaries were also the focus of the ethics and law principle. The principle of evidence-based practice required that decisions about healthcare should be based on the best evidence possible, in accordance with sound clinical expertise and the patient's preferences (von Fragstein et al., 2008, 1105-1106).

Along these major principles, doctor-patient communication trainings have been developed following specific themes, tasks and objectives, required for the effectiveness of the process. One of the studies which elaborated a comprehensive learning programme, entitled UME-21 (Medical Education for the 21st Century), has described extensively the content and methods used to teach communication skills and has provided suggestions for future efforts of integration (Haq et al., 2004, 43-49). Curriculum projects were designed to improve medical trainees' communication skills during the residency years at 12 participating universities. The targeted skills were addressed through a variety of teaching methods and applied in interactions with patients, health teams, and community members. Skills assessment was completed through multiple educational methods such as objective structured clinical examinations, feedback and debriefing sessions based on memory recall, audiotapes and videotapes of doctor-patient interactions. Although the universities designed their own communication curriculum, the ***general communication skills themes*** were:

- *Promoting patient awareness of his rights;*
- *Building core doctor-patient communication skills;*
- *Building conflict resolution skills;*
- *Communicating bad news and managing distressed patients;*
- *Communicating with patient family members and/or specific groups such as adolescents;*
- *Communicating in culturally diverse clinical setting;*
- *Communicating in palliative care and end-of-life cases;*
- *Managing patients' psychosocial issues, e.g. spirituality, sexuality, violence.*

The UME-21 project targeted specific behavioral skills to be developed and assessed. These ***skills*** were considered crucial to "relationship building" and improving patient well-being (Haq et al., 2004, 44):

- *Introducing one's self* – attending to the patient's distress, allowing the patient to complete his/her opening discourse without interruption and establishing the most relevant information.
- *Information gathering* – using effective interviewing techniques, active listening skills to facilitate patient's telling of his/her story (e.g. use of verbal and nonverbal

facilitators, requests for clarification, paraphrasing and summary statements); eliciting information to be able to describe and characterize symptoms to facilitate the diagnostic process.

- *Empathize with the patient* - making an effort to understand contextual factors (e.g. family, gender, cultural issues, socioeconomic status); focus on patient's beliefs, fears, worries, expectations, and his own explanations for the illness; responding in a nonjudgmental manner to patient's discourse.
- *Providing essential clinical information* – providing clear explanations and facilitating patient's understanding by avoiding overuse of medical jargon; checking patient's understanding and correcting the meaning as appropriate; encouraging questions;
- *Reaching a compromise* – encouraging an agreement on problems and solutions, to the extent desired by the patient; assessing patient's compliancy and intent to follow treatment; identifying resources and anticipating any obstacles; negotiating differences in perspective, understanding, and setting goals.
- *Offering opportunity for further questioning* - providing additional opportunities to raise concerns or to ask questions; summarizing and affirming agreement about the plan of action; discussing follow-up procedures.

In addition to these basic skills, the UME-21 project included new communication skills which may be developed (Haq et al., 2004, 49):

- *Negotiation skills* - to achieve compromises when the patient's perspective and that of the physician are not fully aligned;
- *Motivational strategies for behavioral change* - to enhance patient's participation in decision making, to modify high-risk behaviors and to promote healthy lifestyles;
- *EBM training from a patient perspective* - in clinical decision making;
- *Managing medical information from online sources* – information read by the patient on the internet and/or advertised by the pharmaceutical companies
- *Cultural awareness* – to understand and recognize different health values, spiritual practices, and use of alternative therapies.

Apart from the generally recognized skills which should be developed through communication training, other universities have structured their curriculum in a gradual manner in accordance with task difficulty (Kallail, 2011). After acquiring the basic skills in doctor-patient communication, the following educational objectives have been proposed:

- *Responding to strong emotional reactions;*
- *Body language and nonverbal cues;*
- *Culturally-aware communication;*
- *Strategies for promoting change in healthy behavior;*

- *Shared doctor-patient decision-making;*
- *Dealing with sexual issues;*
- *Dealing with spiritual issues and diverse religious beliefs.*

After acquiring the outlines core skills, medical trainees should enhance their competencies by applying all the knowledge in "advanced communication modules", which focus on specific contexts such family interviews, communicating and building relationships with children and parents; adolescent interviews; elderly interviews; tobacco interventions; motivating behavioral change in physical activity; dealing with anxiety and panic disorders; communicating with depressed patients; managing domestic violence situations; managing alcohol addiction; managing drug abuse situations and counseling; dealing with medically unexplained symptoms and the phenomenon of somatization; managing end-of-life care; communication about outcomes from a statistical point of view; setting boundaries in doctor-patient relationships.

Methods of teaching communication skills have included educational techniques meant to improve the experience of developing one's own personal and professional abilities. Two increasingly popular methods of teaching communication skills are simulation scenarios and direct supervision of patient encounters (Person and Finch, 2009, 6). Simulation has become an effective method of teaching clinical skills and manual skills, which were paramount in surgical interventions, but also across all medical practice. Research has revealed that most universities and teaching hospitals provided now simulation-based training at some point during medical education. Research on the benefits of using clinical simulation have identified several areas where human patient simulators or simulated investigations could be applied successfully. Toader (2015) showed that trainees who attended simulation-based training demonstrated improved skills in exploration and identification of lesions, shorter duration for identifying problems and enhanced rapport with human patient simulators. Toader also suggested that more time should be granted for clinical simulation-based training.

The most recent attempt at enhancing the quality of the medical curriculum was established by the "ASPIRE" project (Advancing Skills of Preventive Medicine Residents through Integrative Medicine Education, Research and Evaluation) at the Yale School of Public Health and Yale School of Medicine (Nawaz et al., 2015), which took place between 2012 and 2014. The main objective of this project was to implement a needs-based, innovative training curriculum in integrative medicine through which physicians with competencies in integrative medicine could work in interdisciplinary teams to provide holistic, patient-centered care. Although results showed that efforts to integrate both the evidence-based approach and the person-centered care still present difficult challenges for medical educators, future research should be directed at building efficient doctor-patient relationships in an evidence-based framework.

Future Directions in Medical Education

According to the World Federation for Medical Education, the basic standard regarding doctor-patient communication states that "the medical school must identify and incorporate in the curriculum the contributions of the behavioral sciences, social sciences, medical ethics and medical jurisprudence that enable effective communication, clinical decision making and ethical practices". But within a quality development framework, it is stated that "the contributions of the behavioral and social sciences and medical ethics should be adapted to scientific developments in medicine, to changing demographic and cultural contexts and to the health needs of the society" (WFME, 2007, 16-17). However, current perspectives on medical education and clinical practice indicate to "a crisis of knowledge (uncertainty over what counts as "evidence" for decision-making and what does not), care (a deficit in sympathy, empathy, compassion, dignity, autonomy), patient safety (neglect, iatrogenic injury, malpractice, excess deaths), economic costs (which threaten to bankrupt health systems worldwide) and clinical and institutional governance (a failure of basic and advanced management, inspirational and transformational leadership)" (Miles, Asbridge & Caballero, 2015).

From a psychological perspective, educational theories can provide foundation for teaching methods and curricular improvements, in terms of advancing scientific reasoning throughout medical education within a person-centered framework. First of all, the most important issue is to develop scientific methodologies which would integrate both EBM and PM, that would involve personalizing clinical and research guidelines, but also offering a rigorous framework for the person-centred approach. Secondly, medical education should foster a new way of clinical reasoning that includes exploration of the complexity of scientific inquiry, but also a humanistic appreciation for the heterogeneity of clinical cases found in medical practice (Barz & Achimaș, 2015). Integration of doctor-patient communication trainings into the medical curriculum should be based on relevant empirical findings, while adjusting the content and methods used to universities' resources and cultural setting. Current and future efforts in medical education are aimed at improving practical skills development curricula and focusing on newer methods and techniques which can be used to develop residents' clinical abilities. Including medical psychology courses into the medical curriculum isn't considered sufficient with regard to clinical indicators for quality improvement. Up-to-date design and implementation of doctor-patient communication trainings use simulation scenarios, while recording residents' performance, followed by small-group discussions and video analyses.

New methods of teaching, based on simulation, allow the development of medical competency and aptitudes, in an organized setting, under the supervision of skillful professionals and without any risks with regard to patients. Through progressive exposure to diverse and challenging aspects of medical activities, postgraduate students can improve the quality of healthcare. Complex simulation

scenarios and interdisciplinary teamwork offer greater opportunities for learning and development. This center is meant to ensure quality improvement through the use of high end equipment, but can also grant opportunities for the development of postgraduate students' interpersonal skills. Doctor-patient communication trainings have to be awarded the same amount of importance as granted to the development of technical skills.

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