

# Barriers for teaching communication skills in Spanish Medical Schools: a qualitative study with academic leaders

Roger Ruiz-Moral (✉ [r.ruiz.prof@ufv.es](mailto:r.ruiz.prof@ufv.es))

Universidad Francisco de Vitoria (UFV) <https://orcid.org/0000-0002-6881-9878>

**Cristina García de Leonardo**

Universidad Francisco de Vitoria

**Alvaro Cerro Pérez**

Universidad Francisco de Vitoria

**Fernando Caballero Martínez**

Universidad Francisco de Vitoria

**Diana Monge Martín**

Universidad Francisco de Vitoria

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## Research article

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# Abstract

**Background** In recent years, Spanish medical schools have been incorporating training in communication skills, although how this is being carried out has not yet been evaluated. Our objective was to identify the barriers faced when introducing and developing communication skills teaching in Spanish Medical Schools.

**Method** 34 Medical Schools (83%) were invited to participate in a previous study that explored factual aspects of teaching Communication Skills in these schools. The heads of this subject were contacted at each school and asked to respond to an open-ended question. Two researchers independently conducted a thematic analysis of the responses.

**Results** We received responses from 30 Medical Schools, (85.7% of those contacted and 73% of all Medical Schools in Spain). Five main thematic areas were identified, each with different sub-areas: negative attitudes of teachers and academic leaders, type of organisation, structure and presence in the Communication Skills curriculum, negative attitudes of students, lack or absence of trained teachers and problems linked to teaching methods and necessary educational logistics.

**Conclusions** The barriers identified represent a set of interrelated problems that could explain the way in which Communication Schools are being introduced and the level of priority that many of the Medical Schools give to these skills. The study also shows a wide range of potential ways to intervene to improve Communication Skills teaching and make it more effective in undergraduate medical studies.

## Background

Research carried out over the last few decades has shown that good clinical communication (CC) has a positive influence on many clinical results, including subjective aspects relating to the patient and doctor, physiological results, changes in health behaviour, the clinical relationship, the healthcare process and the economic impact of healthcare [1–3]. There is also scientific evidence that clinical communication can be taught and learned by students, doctors and other healthcare professionals [4–7]. As a result, communication skill (CS) training has for some time been incorporated into undergraduate studies in a number of different countries, with published guidelines advising on the most appropriate and efficient strategies for developing CSs within course curriculums [8-15]. In Spain, the National Agency for Quality Assessment and Accreditation (ANECA) referred to CSs in its white book as a specific competence to be taught in MSs [16]. Furthermore, two years later, an Order by the Ministry of Education and Science, which established the requirements for certifying an official university degree in Medicine, defined them as one of seven competencies that a medical student must acquire in order to obtain a medical degree [17]. Both documents offered a generic declarative perspective on this particular subject, giving accredited schools complete freedom to organise their CS curriculum in terms of the teaching methods and assessments used.

In a preliminary study carried out by our group in 2017, in which 83% (34) of Spanish MSs took part, the current circumstances of CS teaching in Spanish MSs [18] were explored. This study hypothetically concluded that although almost all of them had formally incorporated some content relating to CC in their teaching programmes, there were signs suggesting that, in the vast majority of cases, the way in which CS teaching was undertaken did not follow many of the main recommendations made by the abovementioned bodies. As a result, although many aspects of CC training are still being debated, the efforts made in incorporating it into undergraduate studies may not be effective for the purposes of Spanish medical students acquiring these CSs. Thus, the study showed that a very significant percentage of these MSs (64.7%) only offer CS training during preclinical years, and that it is taught separately from other clinical skills and alongside more theoretical aspects relating to humanities, ethics, history and, above all, psychology. It was also noted that there were no CS training programmes at any stage of the curriculum and there did not seem to be any structured programmes, that is to say, programmes with clear learning objectives and formative and summative assessment strategies, undertaken through internships, with 29.5% of the MSs considering this "training" to be a separate subject. The predominant teaching method was still in a traditional lecture format or seminars in smaller groups where the use of role play or SP (simulated patients: a scarcely used resource) was carried out in a predominantly demonstrative manner, meaning that the majority of students did not get the opportunity to practise individually and receive structured and constructive feedback on their performance. The study also revealed that although the majority of teachers are also clinicians, they lack training and there is a significant number of teachers with no clinical experience or specialities outside of standard clinical practice, especially in psychology. Finally, CS assessment was generally incorporated using the traditional assessment format of a written exam, with very few and generally observational affirmations of the student's communicative level through structured assessments of their performance.

As a result of this, and as a continuation of that study, we proposed a new exploration of the current reality of CS training in Spanish MSs, inviting the same academic leaders that participated in the previous descriptive study to offer, on this occasion, their opinions regarding the problems and barriers that they personally identified when incorporating and implementing CS training in their own MS. The aim of this second survey was to ascertain the current circumstances of the training presented in the previous study and identify the main problems the schools may be facing, while also identifying priority areas for future intervention so as to make the training more effective.

## **Materials And Methods**

This is a qualitative study that aims to explore the problems and main barriers that, in the opinion of the heads of this subject, have been and continue to be faced in terms of developing CC training in undergraduate medical studies in Spain.

In the preliminary study, 41 medical schools (MSs) were invited to participate, taken from the official list of medical schools in Spain published by the Ministry of Health in 2017 [19]. Of these, 34 medical schools, 83% of those contacted, replied, providing information on organisational aspects of the

curriculum (credits, subject/s and year/s in which it is taught, style of teaching), characteristics of the teaching staff and the teaching and assessment methods used in the CC training currently implemented in their schools [18]. Following this, the 34 MSs that participated in the first stage were once again contacted to invite them to participate in the qualitative study (excluding the 7 MSs that did not respond in the first stage). The leaders were asked to respond to the following open question: *"What have been (or are) the main barriers for including (past) and improving (in the future) student training in Doctor-Patient Communication as part of the undergraduate degree offered by your school?"*. The schools were contacted three times over a period of three months (from October to December 2018).

Analysis: All of the results obtained were codified thematically and independently by two researchers, RRM and ACP. The results were sorted into thematic categories and subcategories, with a high degree of agreement regarding the thematic categories. There was a discrepancy in the allocation of subcategories which was resolved by applying theoretical triangulation. We present below the most relevant themes emerging from the results and the number of times that they appeared, displaying the quotes that best illustrate the different opinions shared by staff.

## Results

In the end, out of the 34 MSs contacted, we received responses from 30, (85.7% of those contacted and 73% of all MSs in Spain). These were: Alcalá de Henares, Alfonso X El Sabio, Autónoma de Barcelona, Autónoma de Madrid, Barcelona, Castilla La Mancha (Ciudad Real campus), Castilla La Mancha (Albacete campus), Católica San Antonio de Murcia, Católica de Valencia, CEU Cardenal Herrera de Madrid, Extremadura, Francisco de Vitoria, Girona, Granada, Internacional de Cataluña, Islas Baleares, Jaume I de Castellón, La Laguna, Las Palmas de Gran Canaria, Lleida, Málaga, Miguel Hernandez de Elche, Murcia, Navarra, Oviedo, Pompeu Fabra, Rey Juan Carlos, Rovira i Virgili, Valladolid and Zaragoza. 5 main thematic areas were identified, each with different sub-areas. Table 1 shows a list of the barriers identified

Table 1: Barriers for teaching/learning communicative skills in Spanish medical schools	
Negative attitudes of teachers and academic leaders (as a result of opinions such as...)	Lack of practical use Not being scientific material They are innate skills They cannot be taught Its introduction threatens both their subjects and their own academic status
Marginal presence in the curriculum: organisation and structure	Incorporated as a theoretical subject in an ad-hoc style During preclinical periods In a fragmented way (in different subjects) Part of a subject with other non-clinical content (humanities, ethics, history of medicine, psychology) No transversal structure with coherent teaching aims
Negative student attitudes (as a result of opinions such as...)	They do not understand its use Reductionist and scientific epistemological interpretations It is not important because it is not assessed It is not useful in the MIR (medical intern) exam It is not important because it is of a marginal or secondary nature in the curriculum It is innate, subjective and cannot be learnt
Little and ill-prepared teaching staff	There are no teachers with an influential academic status The clinicians use a weak or negative model They have no training in CS or teaching methods
Teaching and assessment methods needed	They do not use experience-based teaching methods Experience-based methods are expensive It needs more time It needs continuity and the commitment of teaching staff It needs a relatively sophisticated infrastructure It needs complex assessment systems that are not necessarily well known

## Negative attitudes of the university professors and academic leaders

Up to 23 comments highlight the main barrier as being the negative attitudes of the university professors who teach traditional subjects and academic leaders, as well as their corresponding reasons and influence on the way the CS curriculum is incorporated and structured.

- Those responsible for curricula think that CSs are not very useful

*"the inclusion of CC as an interdisciplinary subject or skill was outlandish and unnecessary as it was not considered necessary and time was taken away from real teaching"* U-5

*"teachers of unrelated subjects or content believe it to be "superfluous", "not very serious", "lacking content", etc"* U-11

- Those responsible for the curricula feel that there is no scientific evidence (biomedical) for CSs

*"Many teachers of specialist areas see this subject as "not very scientific", superficial and non-essential"*

U-20

*"Many teachers and members of the School board... believe that the important thing in medicine is basic research and medical knowledge in order to get a good result in the MIR exam, so subjects like this distract students from what is important".* U-21

*"It's believed to be a "soft science" by the academic and professional community, who are more interested in technology"* U-22

- Those responsible for the curricula feel that CSs threaten their own teaching status

*"The fact that the subject or topic is in the hands of family doctors, reduces its value, as the other teachers see them, due to not being full-time staff, as encroachers."* U-19

*"There are a lot of people still in the university, or "establishment", especially in the pre-clinics, who don't see the relevance of these skills in medicine, but there are also clinicians rooted in a medical education model that dates back to the middle of the 19th Century"* U-28

*"because of ignorance and lack of understanding and consideration by academic tutors, most of whom are heads of department and/or full-time lecturers, they don't value it and see it as an "easy subject" that takes lectures on what is really important away from them"* U-17

- Those responsible for the curricula feel that CSs are learned spontaneously

*"The undergraduate degree administrators don't strongly and confidently uphold that training in these skills is key... as they consider it to be something that you learn through imitation"* U-10

### **Type of organisation, structure and presence in the CC curriculum**

These illustrate the most frequent and repetitive types of comments made by key respondents (up to a total of 30 comments) and note that including said skills would primarily be in response to a legal obligation, and therefore, be forcibly implemented without an adequate teaching plan

- Incorporated in an ad-hoc, theoretical way during preclinical periods

*"It's covered in an ad-hoc way as part of another subject, preclinical psychology as well, where it's taught in a theoretical manner with no practical training alongside other clinical skills that are developed during clinical periods"* (U-16)

- Incorporated where it is easiest: together with other secondary subjects

*"... it (CC) is crammed in, given no time of its own, with legal medicine, bioethics, ...and at different points in time which makes it difficult to organise. It seems as though there is no other way to incorporate these skills, and so they are crammed in where there are a few credits leftover" (U-17)*

- Incorporated in a fragmented way with no coherent framework that includes objectives

*"...as it's a "rather unrespected" skill by academic leaders, it's only covered in an ad-hoc and very limited way as part of smaller subjects, often optional, within different clinical and practical subjects, but with no specific objectives (as though the student would be able acquire them "by magic")...it's a genuinely "orphaned skill" (U-26)*

- Necessity to be incorporated into curriculums in a structured and transversal way from a supra-departmental level

*"An institutional barrier, of a structural kind of great importance, is that curriculums do not incorporate the subject in an obvious way. In general, they recognise the need for it but do not explain how it will be carried out and where the necessary credits will come from" (U-23)*

### **Negative student attitudes**

Up to 11 comments identify students' attitudes towards CC as a major barrier. The respondents link these attitudes to a number of different causes

- Negative attitudes towards CSs because of a lack of understanding as to why they are useful

*"It's basically covered in second year psychology when the majority of students are, in my opinion, not mature enough to understand the importance of this topic in their future clinical roles" (U-13)*

*"The main barrier is that the subject is covered in second year medicine, at the same time as the Golgi apparatus, cranial nerves and the Starling Law, so for the students its use is relative, given that it will be at least another two years before they work with patients and can see why it's important to their work as doctors" (U-28)*

*"The students don't give much importance to communication as it's taught in the third year and they are perhaps not aware of how important it will be in their future clinical work" (U-25)*

*"By teaching this subject in the second year, the students don't think it's very important for their future work as doctors" (U-20)*

- Negative attitudes towards CSs due to biomedical epistemological interpretations

*"Many students believe that the education consists of gaining a lot of medical knowledge" (U-17)*

*"Students tend to want to "objectivise" all the assessment schemes (when tackling exam revision, trying to boost results and competing for grades). This makes an overall assessment of communicative skills*

*difficult and entails going through meticulous and debatable evaluations" (U-11)*

*"We've seen disinterest among students in attending classes because they think it can be substituted by private study based on notes" (U-8)*

- Negative attitudes towards CSs due to it not being assessed

*"Although student attitudes have changed in the last few years,... due to not being (CC) a continuous feature of a stable assessment scheme... they don't have enough motivation to study it" (U-23)*

- Negative attitudes towards CSs due to it not being useful in the MIR exam

*"Medical students continue to have a pre-academic profile for the MIR exam which prioritises the absorption of knowledge... so it has a passive role in internships, with no or little feedback or reflection on their communication...they are demotivated" (U-24)*

- Negative attitudes towards CSs because of how it is included and taught in curriculums

*"By including it as something secondary within other subjects, generally pre-clinics, using inadequate teaching method, if any, and with no thought as to how it is assessed, students see it as something that is not very important or is more something related to their own personality" (U-26)*

### **Lack or absence of trained teachers**

There were 13 comments that made reference to the lack or absence of trained teachers, not only when it comes to adequately teaching the content (offering feedback, etc.) but also in terms of adequately planning it in the curriculum:

*"There aren't enough trained associate teachers involved in this subject area to be able to establish proper parameters for communication skills, teaching objectives and teaching methods" (U-4)*

*"There aren't enough trained teachers to teach it properly. It is left "in the hands" of the teaching clinicians in charge of clerkships. The psychologists don't generally have trained teachers that know practical medicine" (U-5)*

*"Perhaps the most significant barrier is the lack of training that many teachers have in this subject" (U-23)*

*"There aren't enough teachers (associate teachers)" (U-24)*

### **Problems linked to teaching methods and the necessary educational logistics for it to be taught**

There are 21 comments that consider the characteristics of the teaching and assessment method designed specifically for learning CC effectively is a significant barrier.

- Technical/infrastructure requirements

*"The type of teaching necessary: active learning environments, with simulated patients, video recordings, self-evaluation..." (U-9)*

*"It requires a specific infrastructure for it to be carried out, spaces for simulation, video recording and reproduction systems..." (U-14)*

*"We would have to hire semi-professional actors to help teach it and make more time for simulated activities" (U-25)*

- Insufficient time

*"The main barrier we face in communication workshops is, without a doubt, a lack of time,...for students to individually put into practice what they have learned, give subsequent feedback on how to improve any error made in the practice interview with a SP" (U-19)*

- Structured feedback

*"Every student would have to be given personalised feedback while interacting with simulated or real patients" (U-23)*

- Continuity and commitment of teaching staff

*"...has to be taught on an almost one-to-one basis and requires a lot of commitment by teachers...this means giving it its own budget and having to manage significant resources" (U-9)*

*"It's not thought that this type of learning needs to be continually incorporated throughout the degree. It's thought that by merely studying subjects such as psychology, oncology, palliative care or psychiatry, students will learn communication skills...in reality, when on internships, which is when students are faced with communication problems, they really are alone. In general, there is no feedback given by faculties" (U-26)*

- Budget

*"This subject would have to receive more investment than others: SP, Gesell chamber..." (U-30)*

- Problems deriving from the type of assessment that communicative skills require:

*"Assessment makes it (CC) a major burden. Exams here are worthless, they should be assessed on what they do, how they really communicate and not what they know" (U-11)*

*"The need for more complete assessment of its impact on OSCEs" (U-14)*

*"The students have to take an objective test (simulated exam with a standard patient) for the skills they've acquired to be assessed...and this is difficult to carry out and expensive" (U-19)*

*"It's not assessed in a specific way, if it's done indirectly, and when that happens, they are generally criticised on what they have done wrong and then they (the students) complain" (U-26)*

*"the students don't understand that they are being assessed on something like CC that many think is an innate skill" (U-29)*

## **Discussion**

In this qualitative study, those responsible for CSs in their MS offer their opinions on the most significant problems or barriers that they have personally identified when incorporating and developing these skills. Although both the barriers identified and their possible causes are not exclusive to the medical undergraduate studies in Spain, both the general opinion given and similarities between the statements offer their own perspective on the influence that these barriers and their dynamics have on our educational environment. This should uncover possible intervention strategies so that, when it comes to individual circumstances, each school can outline ways to improve and progress towards a more efficient approach to teaching CSs.

With varying degrees of importance, the barriers identified here have already been highlighted in an isolated fashion in recent years. The belief that communication is something innate and lacking academic credibility, as it is socially subjective and not a comparable science that can be taught, is something that, although identified in other places [20, 21] seems to be especially relevant not only to academic leaders and teachers of other subjects in Spain, but also to many of the students [22]. This interpretation reveals the influence of the biomedical paradigm on academic medicine in terms of determining what is correct and incorrect to research, teach and, surely, do in practice. Several studies show the extent to which the introduction of humanities and social sciences in medical curricula is burdened by such hegemonic thinking [23-26]. This study also highlights how, in the key respondents' opinions, the influence of this ideological hegemony on incorporating and developing CSs in MS curricula in Spain seems to be a determining factor. In effect, if the barriers identified are considered as a whole, it forms a coherent and revelatory picture of the problem: In an educational environment dominated by biomedicine, the role of some of the negative attitudes by teachers and academic leaders towards this subject stands out, primarily due to, according to the respondents, their belief that CSs are "not scientific" and are innate skills, but also to other factors relating to the current power status of universities in Spain. This would mean that the legal requirement for it to be incorporated and implemented in the medical curriculum, that characterised the ministerial order of 2008, would apparently only be on a temporary basis, in periphery or secondary positions, such as in certain subjects covered during the preclinical stage, and without an integrated and coherent teaching plan. Furthermore, when CSs are taught as part of these basic subjects or in a theoretical way by teachers who are not clinicians and not during clinical periods by general doctors, specialists or surgeons, it sends a tacit message to students that clinicians are people who know the fundamentals of medical practice while the others are specialists in psychosocial and less scientific topics [27]. It also sends the message that CSs are an objective in themselves and not a tool that allows for a better quality of patient care [28].

Likewise, the difficulty of incorporating more sophisticated (experiential) and adequate teaching and assessment strategies for this type of teaching, represents a barrier that seems to contribute in itself to the fact that learning it is having little impact on the students, and we can see that this is linked to both the lack of teachers trained to implement it and the difficulty and disinterest to invest in the resources required to teach it. The absence of practical training based on observation and feedback is not, however, something exclusive to the Spanish education system [29-31], nor is having an "informally made" CS training plan "without structure, sufficient time and defined objectives" [32]. Even structured training can in itself have a negative impact on students' perceptions, if adequate teaching methods are not used [33]. It has been observed that those students who receive less experiential training in CSs, consider to a lesser extent, communication as a skill that can be learned and used to improve clinical results [34]. The use of experiential training methods is recommended (role play, interacting with simulated patients, practice followed by feedback, etc.) for both teachers and students [35]. However, students may view these experiential sessions in a negative way if they are not carried out in an environment which is safe, trustworthy and free from prejudice [22,35].

This shows that having staff trained to implement this type of teaching is key, as their absence or scarcity is identified as a major barrier by our respondents. In effect, clinicians interested in the topic complain that they have little training in communication and little confidence to teach and assess skills that they themselves have not fully mastered [36]. Furthermore, this lack of teacher training also extends to deficits in the skills that can be taught [37]. Teaching CSs in a clinical practice requires teachers who believe in it, show and practise it [38]. This is particularly important because deficiencies in CS teaching can occur if medical supervisors do not feel that it is essential knowledge for a clinician and/or that it cannot be taught [38]. In addition, clinical supervisors tend to teach CSs through role modelling, in a very irregular and rarely explicit manner [39]. When clinical supervisors address communication problems with residents and students, they generally tend to intervene in the role of corrector, clinician or trainer more than as a teacher [36]. Many of them hope that by simply watching and listening, young doctors will recognise, accept and copy desirable behaviours and skills [40]. Trusting CS training to role modelling during clerkships carries great risks, as clinical supervisors have generally noticed that these models do not possess all of the skills [41]. Our respondents also highlight the absence of teachers in relevant and influential posts that defend this subject and who could contribute to changing the curriculum.

With regard to the weight that CSs carry in the Spanish assessment system and the way in which CC is assessed, this assessment has a counter-productive effect on the skills. In general, Spanish MSs do not always assess CSs in a specific way and, when they do, they assess it through multiple choice questions in a written exam, or in a generic way with a list of generic skills to be filled in by the supervisor at the end of the clerkship or, at best, using unsuitable checklists, which sends students a message of how important the system thinks these type of skills are and it is not usually well received [42, 43].

Finally, students and young doctors are described as having negative attitudes towards CSs and do not try to learn them. In addition to the belief of many that communication is something innate and subjective that cannot be taught [20, 21], there are also personal factors as the students with the most

positive attitudes towards CSs tend to be women, have parents that are not doctors or believe that their CSs need improving [44]. Students' attitudes can also vary according to their level of experience. It has been seen that young doctors without experience are more stressed and less open to communication problems than those with more experience because they are still concerned about providing accurate diagnoses and quick and appropriate care [36]. Good communication tends to be hindered by difficulties that lead to poor knowledge of biomedicine, clinical reasoning and a lack of skill in using technical procedures (electronic medical registers) [41,45]. However, having said that, it must be noted that the abovementioned factors, without a doubt, also contribute greatly towards students not only seeing the usefulness of CC for practising medicine but also in many cases contributes to confirming the conflicting attitudes they have towards this type of skills and reaffirming any biomedical reductionist and scientific epistemological interpretations that they may have of medicine and CC, which as a whole could be seen as a vicious circle that is hard to break out of.

However, despite everything, several studies also show that young doctors and students value CSs and hope that they will be taught in MSs and residence programmes [46-48]. They also hope that their clinical supervisors will take a more active role in observing them and offering feedback on communication [49,50]. Student representatives in Spain have made these requests explicit [51]

## Conclusions

Those responsible for introducing and developing CSs in Spanish MSs identify a set of barriers that would make it difficult for students to effectively learn these types of skills and, in line with the above, represent a set of interrelated problems that largely explain the way in which CSs are being introduced and the real priority for them to be taught in Spanish medical schools. Teaching CSs, as with other social science or humanity subjects in medicine, would therefore be a challenge for MSs in terms of adapting them to new educational models that are more in line with new teaching and clinical practice trends.

## Abbreviations

**CS:** Communication Skills

**CC:** Clinical Communication

**MS:** Medical School

**SP:** Standardized Patients

**U:** University

**RRM:** Roger Ruiz Moral

**ACP:** Alvaro Cerro Pérez

# Declarations

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Ethics approval: UFV Health Sciences Faculty review board (IRB), considered this study congruent to ethical and legal established requirements, and gave its approval.

Consent to participate: Informed consent to participate in the study was obtained from all the survey respondents

### *Consent for publication*

Not applicable: This manuscript do not contain any individual person's data in any form

### *Availability of data and material*

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### *Competing interests*

The authors declare that they have no competing interests

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### *Authors' contributions*

RRM and FCM, conceived the project and participated in its design and coordination for the all Project. RRM and DMM implemented the question. CGL, DMM and ACP contacted with deans, academic leaders and CC teachers in all the universities. RRM and ACP carried out independently the thematic analysis and codifications of the survey responses from the. Both authors and DMM were involved in triangulation process. All authors developed and discussed the interpretation of data; they also drafting the manuscript. All authors reviewing it critically for important intellectual content.

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