THE MEDICALIZATION OF COMMUNICATION: AN ANALYSIS OF THE POLICIES AND EDUCATIONAL PRACTICES SURROUNDING PATIENT AND PHYSICIAN INTERACTION

by

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Abstract

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Surrounding Patient and Physician Interaction

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This dissertation explores the medicalization domains through three studies to assert that communication exists in all facets of the patient- physician relationship. The first study is a policy analysis that examines the *institutional domain* through policies and educational standards created in the medical community that dictate the importance of communication. The second study examines medical students' level of clinical empathy using the Jefferson Scales of Empathy. The second study ties to the *conceptual domain* of the medicalization of communication, showing the creation of terminology (i.e., clinical empathy, clinical communication) helps uniquely identify and measure empathy through communication. The third study examines residents in practice and utilizes the *interactional domain* of communication needed to provide clinical outcomes by creating shared goals between patients and physicians. All three studies provided a comprehensive examination of policies and educational practices surrounding the patient-physician interaction and serve to build a model of the medicalization of communication through all three domains: institutional, conceptual, and interactional.

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CHAPTER 1

INTRODUCTION

Communication is described as the process of exchanging messages with a shared meaning between individuals or groups (Shannon & Weaver, 1949; VanPatten, 2016). This becomes increasingly complicated when the message consists of medical knowledge needed to be understood by a layperson, particularly a patient who has to make health care decisions based on the health-related information received and the multitude of care options to be considered. Effective communication is vital in treating patients because when medical errors occur, it can lead to negative ramifications for the patient, physician, and the health institution such as medical malpractice, lawsuits, or even loss of life (Hoffman et al., 2015; Kaplan-Liss et al., 2018). Although tools for more effective communication have been established, 30% of malpractice cases continue to involve miscommunication (Hoffman et al., 2015). That being stated, it is important to note Kaplan-Liss' (2018) estimation that over 65% of adverse patient outcomes stem from poor communication.

The medical community has recognized that communication is a critical part of patient safety and has recently received special attention in medical education (Henry et al., 2013; Kaplan-Liss et al., 2018; Woods et al., 2018). The addition of communication into medical education curriculum through accredidation agencies has led to an influx of innovative teaching practices and an increased focus on understanding effective interactions between patients and physicians. Even though verbal communication is a primary step in patient-doctor interactions, until 2014 it was not included as a testable requirement for medical students to earn their license. In addition, since communication training is a new field, there is still debate on the types of communication that should be integrated within the education and practice of medicine (London,

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2021; Mohd Hanafiah et al., 2021; Wittenberg et al., 2021; Yudkowsky & Szauter, 2021). Types of communication such as intercultural, interprofessional, persuasive, empathetic, and crisis communication, have been discussed in various studies (Broukhim et al., 2019; Germaine et al., 2021; Mohd Hanafiah et al., 2021; Wittenberg et al., 2021). This dissertation examines various communication trainings and how it affects medical learners and physicians (Hojat et al., 2002; VanPatten, 2016). Thus, by examining variables such as gender, year of experience, and medical specialties, we can identify the commonalities and differences in the medical learners' skills regarding communication.

Most recently, COVID-19 created potential changes in medical education since it has been recognized that "new approaches have the potential to catalyze the modernization of U.S. medical education . . ." that included crisis communication and electronic adaptation (Lucey & Johnston, 2020, p. 1034). During the COVID pandemic, communication with patients had to adapt quickly to virtual settings (Wittenberg et al., 2021). Communication issues also arose regarding how to convey empathy to patients, particularly with healthcare teams, medical students, and patients wearing protective equipment, being in virtual spaces, and affected by the myriad of changes to policies and practices (Wittenberg et al., 2021). The way medical students and residents were trained also faced changes caused by physical distance or operating completely in virtual settings, which made communication one of the most complex issues in medicine (Wittenberg et al., 2021). Wittenber et al. (2021) noted "as families must remain isolated from COVID-19 patients, communication between providers, patients, and families are reduced and require communication techniques that match new and changing contexts" (p. 439). The pandemic highlighted the need for diversification of the communication types used in medicine (Brem et al., 2021; Finset, 2021). Researchers and practitioners rapidly discovered that

these changes in interactions between healthcare teams, patients, and families lacked the communication resources needed to practice empathy and humility, while maintaining professionalism to help with decision making (Finset, 2021; London, 2021). Research also identified a need to provide more resources for strengthening communication skills in areas such as empathy, compassion, and cultural sensitivity (Back et al., 2019; Kaplan-Liss et al., 2018; Wittenberg et al., 2021).

Training in empathetic communication has also been shown to reduce burnout in healthcare workers (Kerr et al., 2020; Varpio et al., 2018; Wittenberg et al., 2021). Burnout refers to a syndrome causing an emotional detachment from an occupational role due to stress and exhaustion (Varpio et al., 2018). Burnout has a negative effect on patient care and is most prevalent in the healthcare field, observed specifically with physicians (Boissy et al., 2016; Ramirez et al., 1995; Varpio et al., 2018; Wittenberg et al., 2021).

The need for communication is considered critical for patients because it "enables them to share in decision making that will result in medical treatments and social supports that are aligned with their goals and values" (Back et al., 2019, p. S434). Even with research favoring the inclusion of communication in all areas of medical education, some medical specialties such as palliative care, hold more priority over others and can be looked to as examples of effective communication (Back et al., 2019; Brown et al., 2008; Finset, 2021; Gerber et al., 2020). Education standards and policy surrounding communication provide different perspectives on the types of communication needed in the educational environment and the practicing of medicine (Mohd Hanafiah et al., 2021; Mohiaddin et al., 2019; Stevens et al., 2020). For instance, over the last several years, policies focused on communication training in medical education have been removed from curriculum for medical students, but were added for medical residency (Howley &

Engle, 2021; Katsufrakis & Chaudhry, 2021; Paniagua et al., 2018). From a policy perspective, the shift in communication training created the need for more explicit standards for educators, medical learners, and physicians. In this dissertation, medical learners term refers to medical professionals entering the field that are in either medical school or residency. Policies in medical education and clinician training require an inclusion of communication curriculum and the adoption of communication frameworks (Back et al., 2019; Kwong, 2017; Liu et al., 2017).

To better understand changes and needs surrounding medical communication policies and practices, this research proposes to use the frameworks of medicalization. Although the notion of medicalization is traditionally used to describe the process by which aspects of human life are defined as medical problems, the concept has been expanded to include the interaction between physician, patient, institution, and organization (Conrad, 1992; Conrad et al., 2010; Parens, 2013). Similarly, medicalization can be used to identify the process by which communication has become an integral part of the medical field. Therefore, in this dissertation I will make an argument that the insertion of communication in medicine as an important training and practice tool can be characterized as a medicalization of communication.

Background to the Problem

This background section will examine literature and information about medicalization, the physician practice, followed by the effects of communication on medical policy, educational policy, and medical education.

Medicalization of Communication

What is Medicalization? Medicalization has been used in medical sociology since the 1960s and expanded to areas including history, public health, medicine, anthropology, literature, and technology (Clarke & Shim, 2011; Conrad, 1992; Joseph, 1967; McIntosh & Rock, 2018).

Specifically, medicalization examines medical society's influences on culture based on its definitions of health (Donaldson, 2008; Foucault, 1973; Goffman, 2017; Joseph, 1967; London, 2021; Parsons et al., 2019). Cockerham (2013) discusses the spread of the medicalization term to describe the influences of society on medicine. Changes that occur within medicine that affect both patient and physician can be described as being medicalized (Conrad, 1992). Like any other aspect of human life that can be labeled and considered a medical problem, the policy, education, and practice process that brought communication into the medical field can be described as the medicalization of communication.

Before discussing the aspects that make up the medicalization framework, I will present several characteristics of the concept that drive changes in the medical domain. An important characteristic of the medicalization process concerns the assumptions about the roles of various participants (e.g., patients, physicians, caretakers, insurance companies, employers, and other stakeholders) in the medical domain. Once those assumptions are understood, the significant domains of medicalization regarding medical practice, policy, and education and how they relate to the physician and patient interaction will be introduced.

Patients as Consumers. Patients must have the skills to navigate medical information which distribution is impacted by multiple factors including technology, patient access, and accessibility to resources. A significant element in medicalization is seeing patients as consumers "in a culture of increasingly market-driven medicine, consumers, biotechnological corporations, and medical services interact in complex ways that affect social norms in changing definitions of behaviors and interventions" (Conrad, 2007, p. 144). Conrad's comment on complex interaction lends itself to discussing the patient's power in organizing and controlling medical information about themselves and their family. Physicians are also consumers of different technologies to

diagnose, treat, and communicate information for patient care (Abraham, 2010a; Clarke & Shim, 2011). Seeing patients as consumers means they have options, but the interaction with their physician should help them navigate available care choices.

The internet and medicine are now deeply connected and come with challenges and benefits to the patient-physician relationship due to accessibility of knowledge by every stakeholder in the healthcare environment (Drentea & Moren-Cross, 2005; Fox et al., 2005). Technology allows consumers to compare medication, treatment options, and health strategies to find the ones that fit their needs (Maturo, 2012; Miah & Rich, 2008). Medical preapprovals and insurance coverage gatekeep procedures, medication, and even access to certain physician specialties. Therefore, the patient consumers use technology to make health decisions and discuss options with physicians (Clarke & Shim, 2011; Miah & Rich, 2008). People have information and choices, but physicians are still a part of the health interpretation process. The job of the physician is to present those choices in a way that the patient or caregiver understands while taking patient barriers, access, and preferences into consideration for a negotiated treatment plan.

Managed Care. The healthcare that people can obtain is limited by the resources available to both the patient and physician (Abraham, 2010b; Clarke & Shim, 2011; Conrad, 2007; Parens, 2013). Managed care refers to the actions taken by patients, physicians, and other organizations such as insurance companies and employers to reduce cost while maintaining care (Conrad, 2007). Those economic constraints, combined with technology and consumerism, create an environment where patients and physicians must navigate the managed care for treatment plans (Kaczmarek, 2019; Parens, 2013). Managed care has led to the patient being an informed consumer and a stakeholder in the medical community (Conrad, 2007; Kaczmarek,

2019; Maturo, 2012; Parens, 2013). Patients would like to choose the doctors they want (i.e., as consumers) but with the rising cost of healthcare, they have limited resources based on insurance coverage or not having insurance at all (Maturo, 2012). Therefore, communication between patient and physician is essential in allowing both stakeholders to make decisions based on economic limitations and incentives, including those related to medications and procedures (Conrad, 2007).

Managed care relies on the medical community that has control over the definition of illness and criteria for diagnoses. It includes physicians who are educated professionals that are also one part of multiple stakeholder groups that rely on the interaction with patients and caretakers (Eaglen, 2017; Fishbein, 1946; Joseph, 1967; Strauss, 1984). Patients and physicians are at times required to get preapprovals for health needs from insurance companies, clinics, and hospitals (Conrad, 2007; Parens, 2013) which is part of the managed care process.

Effects of Medicalization. Recognizing the interaction between patient and physician has a lasting effect on the constraints and opportunities of all individuals involved in healthcare. The more extensive the healthcare system becomes more important is the understanding of each other healthcare partners. That understanding applies to individuals with different access to resources, which in this case is knowledge. Therefore, the manner the interaction occurs can determine much more than healthcare decisions but can change the outcome of one's health altogether (Byrd et al., 2020; Germaine et al., 2021; Salmon & Young, 2011).

Medicalization of communication has a lasting effect in every area of the medical practice, including ethics, privacy, and medical training (Clayton et al., 2013; Parens, 2013). Therefore, medicalization can be examined through changes in society by creating medical terminology, defining the interaction between patients and physicians, and changing institutional

requirements for physicians (Cockerham, 2013; Conrad, 2007; Conrad et al., 2010). More important, the types of communication needed for physicians can be established using the medicalization framework to examine the education and policy that affect the patient-physician relationship during the managed care process.

History of Medical Communication

The physician practice has grown from pseudo-scientists and shamans to a profession based on scientific discoveries and medical education (Cockerham, 2013; Victor, 1910). The profession went from an apprentice-based vocation to a scientifically trained occupation (through higher education) using political power and a licensing system (Fishbein, 1946). Following these changes, the use of communication in medicine has evolved too.

History of Communication in Medicine. Initially, medical communication was viewed as a natural skill that could not be taught (Moore et al., 2012), and only some physicians would possess it. However, improper exchange of information between physicians and patients has become common occurrence that can lead to patient harm and create stress for both patient and physician (Hoffman et al., 2015). Miscommunication in the field of medicine was originally thought to be caused by the patient since physicians felt their job was mainly to inform the patient of specialized medical knowledge and the patient would follow the doctor's orders (Ferreira-Padilla, et al., 2015).

As medicine has evolved and more specialized knowledge is required to be able to treat patients, and more patients had access to medical information, communication has become more integrated in medical training because research showed the physician interaction with patient resulted in positive clinical outcomes (Ferreira-Padilla, et al., 2015). The changes in communication within medicine date back to the 1990s with reports from multiple agencies

worldwide. Since then, it has been added to the medical curriculum and is a part of medical training and evaluation of the patient-physician relationship.

        History of Communication in Medical Education. Understanding how communication was incorporated in training future physicians involves looking at the development of the physician profession and the research surrounding the patient-physician relationship. Governing bodies like the General Medical Council's stance is that patient-centered communication could and should be part of medical education (Christopher et al., 2002). That statement led to communication being taught worldwide in medical schools (Brown, 2008; Ferreira-Padilla, Ferrandez-Anton, et al., 2015; Moore et al., 2012; Novack et al., 1993; Richards, 1990). Shortly after the General Medical Council's report in 1996, the Association of American Medical Colleges (AAMC) introduced communication competency standards, requiring medical education to have an assessment of students' communication skills (The Medical School Objectives Writing Group, 1999).

        As students move from medical schools into medical practice and direct interaction with patients, they must engage in post-graduate residency training. Residency has an advanced set of competencies that prepare student physicians with specialized and applied skills before independent practice. The Accreditation Council for Graduate Medical Education (ACGME) began measuring competency outcomes and one of the focuses was on communication with patients, families, medical teams and interprofessional groups (Swing, 2007). As recognized by many researchers, medical education is evolving, and the care for patients relies on different types of communication (Finset, 2021; Germaine et al., 2021; Wittenberg et al., 2021).

Communication in Medical Practice

     Outcomes of Communication. According to patient satisfaction surveys and the positive clinical outcomes that are being researched currently, communication in medicine is valued because it shows understanding, respect, and leads to empathic interactions between the patient and physician (Hall & Schwartz, 2019; Kaplan-Liss et al., 2018; Piumatti et al., 2019; Pollak et al., 2011; Wittenberg et al., 2021). Even with this knowledge, some scholars debated the types of communication best suitable for the patient-physcian relationship (Smajdor et al., 2011; Vinson & Underman, 2020). Regardless, when communication research began to emerge in the field of medicine, it was discovered that positive patient and physician interactions lead to improved clinical outcomes and less stress for all stakeholders (Brown, 2008; Cegala & Lenzmeier Broz, 2002; Gerber et al., 2020; Harrington et al., 2020; Moore et al., 2012). Furthermore, the interaction of the two parties can have lasting effects on the health decisions made by the physician and patient (Back et al., 2019; Zwingmann et al., 2017).

     Shared Healthcare Goals. The communication in medical practice occurs during the interactions of medical personnel with patients, and at times family, about the values, needs, and concerns guiding physican's decisions formally described as "goals of care" (Wittenberg et al., 2021). Communication in medicine leads to creating care goals for the patient (Mott et al., 2021). The "goals of care" viewed as a shared decision-making process is enhanced by evidence-based communication during which the physician has to also convey empathy, compassion, supportive listening, and cultural humility (Hall & Schwartz, 2019; Mohd Hanafiah, et al., 2021; Spagnoletti et al., 2018; ten Cate et al., 2021; Wittenberg et al., 2021).

     Shared decision-making regarding care is dependent upon conversations between a patient and physician (Mohd Hanafiah et al., 2021). Effective communication can empower the

patient and the medical professional by allowing for joint decision-making (Suojanen et al., 2018). Communication (or lack of it) is one of the primary barriers to making this shared decision (Aleksova et al., 2016; Mott et al., 2021).

The communication confidence of medical students and physicians can have a lasting impact on patients' care. COVID-19 has shined a light on this communication aspect in medical education, and as medicine changes, it is essential to understand how communication fits into the new medical practice (Brem et al., 2021; London, 2021; Mohd Hanafiah et al., 2021; Wittenberg et al., 2021). Individual programs in medical schools will determine what type of communication should be included in the medical curriculum and physician practice, and as such, studies on what works best within the collaborative nature of medicine are necessary.

Communication Policies and Standards

Policy in Medicine. Communication policies and standards appear in multiple areas of a physician's practice and medical education, from the code of ethics to the educational standards in training new physicians. Fowler (2013) describes policy as a way of examining the problem and creating the solution by a governing body that examines requirements for each group of medical practitioners. Communication skills have continued to be policy topics and the debate has intensified over the past few years (Harrington et al., 2020; Spagnoletti et al., 2018; Wittenberg et al., 2021). The analysis of medical policy documents and the concept of medicalization helps establish that communication is constantly changing in the medical field, from interacting with patients about their health to promoting community health (Cockerham, 2013).

Governing Bodies Creating Policies. The American Medical Association (AMA) was established in 1847 and guides the code of ethics in medicine (Gambert, 2007). The guideline

has added communication elements regarding patients' consent, electronic communication interaction policies, and the rights physicians and patients have within the healthcare environment (Gambert, 2007). The code of ethics even discusses the social media expectations of physicians regarding television appearances and political conversations (Gambert, 2007). In addition, organizations like the AMA and The Health Insurance Portability and Accountability Act of 1996 (HIPAA) create guidelines for physicians, patients, and medical learners regarding ethical principles and policies involving shared communication (Hojat et al., 2002).

Examining policies and standards gives a glimpse into the shared values regarding communication within the medical profession (Cockerham, 2013; Ferreira-Padilla et al., 2015; Foucault, 1973; Lucey & Johnston, 2020; Suojanen et al., 2018). Furthermore, policy changes in the medical profession directly affect policies and standards, thus affecting the future of medicine.

Communication in Medical Education

Development of Competencies in Education. New competencies in medical communication have been added as recently as 2020 by both Accreditation Council for Graduate Medical Education and Association of American Medical Colleges governing bodies (Ferreira-Padilla et al., 2015; Kaplan-Liss et al., 2018; Makoul, 2001; Moore et al., 2012; Richards, 1990; Swing, 2007). Both accreditation agencies have the fundamental belief in evidence-based development of patient-centered communication that leads to better care. Salmon and Young (2011) describe how communication assessment is more than "demonstrating communication skills." It also requires a directive of "skilled communication" to affect patient interaction. Accreditation agencies and researchers in medical education are realizing the need to focus more on physician communication (Back et al., 2019; Chidume et al., 2020; Geoffroy et al., 2020;

Gerber et al., 2020; Mohiaddin et al., 2019). For residency as well as in undergraduate medical education, accreditation agencies are creating competencies that require an evaluation of communication skills. Although communication training is still in the early phases of development that follows changes in education standards, there is a belief in a holistic approach to govern medical communication education.

Clinical Competency and Communication Types. The medical learner's communication skills involve gathering information, providing support, and enabling patient behaviors that lead to allowing them to make decisions, all while interacting with patients and families legally and ethically (Drew & Thompson, 2005). Different types of communication models are being used to help medical students learn about clinical interaction, though it is not clear if any of these models ensure that medical learners are gaining all necessary skills for clinical interactions that reduce miscommunication (Broukhim et al., 2019; Kaplan-Liss et al., 2018; Kurtz & Silverman, 1996; Makoul, 2001, 2003; Marathe & Bansal, 2018; Wolfe et al., 2018). Therefore, having an effective communication skills training model continues to be an unresolved issue in medical education.

The changes in policies from as recent as 2021 will likely lead to individual programs in medical schools having to determine when and where communication should be taught in the undergraduate medical curriculum (Fatima et al., 2021; ten Cate et al., 2021; Wittenberg et al., 2021; Yudkowsky & Szauter, 2021). Medical programs also have to determine the type of communication that is the most beneficial to learners that would prepare them work within the structure of the medical community (Finset, 2021; Lucey & Johnston, 2020; Morrison et al., 2020). Examining the medical policies, the medical education and training, and how various groups of medical learners practice communication in medicine helps better understand the types

of communication valued in the medical domain and would contribute to build a medical communication model.

Statement of the Problem

Medical education has changed over the past decade as shown by new policies and practices aimed to define the future of medicine in the United States. The pandemic has also added specific changes in policy, practice, and medical education regarding medical communication (London, 2021; Mohd Hanafiah et al., 2021; Wittenberg et al., 2021; Yudkowsky & Szauter, 2021).

Communication research has determined that interaction skills are necessary in the medical practice, but debate exists on the useful types of communication to be taught to students (Brem et al., 2021; Perez, 2021; ten Cate et al., 2021). There is also debate about where communication should be taught in the medical curriculum and what communication policies are essential to the well-being of physicians and patients (Fatima et al., 2021; Lucey & Johnston, 2020; Rajesh et al., 2021; Torda, 2020). Although existing communication research has focused on different medical specialties' needs, it has not addressed broader perspectives such as the policies that govern the profession, communication types in the education of physicians, and how communication is practiced in medicine. Communication is discussed as something to be useful for patients, but not as a fundamental part of every aspect of medicine. Therefore, there is a need to understand the types of communication needed by clinical personnel and patients to better educate future physicians and serve the health community.

Purpose and Objectives of the Study

The purpose of this dissertation is to examine relevant policy and practice issues pertaining to the use of communication skills in the medical profession related to patient and

physician interaction and the training designed to acquire these skills within the medical

education. The objectives for this research are as follows:

1. To examine the *institutional* policies and standards regarding the use of communication
   in medical practice and education.

2. To explore how types of communication are *conceptualized* when educating medical
   learners.

3. To examine how medical education utilizes communication training to improve the
   interactional process between the patient and physician during the health care provision.

Conceptual Framework

Medicalization Domains

The purpose of this dissertation is to explore the types of communication as they appear

in the policies, education, and practices of medicine. The research is guided by the framework of

medicalization as defined in this section. Conrad (2007) characterizes medicalization as being

transformative to the medical profession and supporting patients' care in any one of three

domains defined as conceptual, institutional, or interactional. The medicalization framework has

been used in other contexts in the past (Cockerham, 2013; Conrad, 2007; Maturo, 2012), and this

dissertation will explore how types of communication (i.e., intercultural, interprofessional, and

persuasive communication) have expanded into medicine using these three domains.

Institutional Medicalization. The institutionalization of medicine can be seen as a form

of socialization in "institutional training" as well as "educational credentials" of a given group of

medical learners (Cockerham, 2013, p. 146 & 263). In other words, institutional medicalization

refers to the response from the medical community to different phenomena through mandates,

policies, and educational standards. Medical organizations and the government have created

laws, policies, and standards surrounding communication that dictate the requirements to become a physician and maintain the physician status. Therefore, institutional medicalization can be examined through the medical profession's policies and standards. Applied to communication, this domain has the role to socialize future physicians on the importance of communication and how to utilize different types of communication before they enter into the medical practice (Bayne, 2011; Cegala & Lenzmeier Broz, 2002; Suojanen et al., 2018).

Conceptual Medicalization. Conrad (2007) and Maturo (2012) discuss conceptual medicalization as changing the lexicon to create new medical terms to define things that may be considered medical. Maturo (2012) uses the example of the diagnosis of mammary ptosis, the natural drooping of the breasts after pregnancy, as a lexicon to define a nonmedical entity (page 123). An example discussed in this dissertation is clinical empathy, which is a term used to define how to express empathy- verbally and nonverbally to build trust with patients, while maintaining clinical objectivity within this empathetic practice (Kaplan-Liss et al., 2018; LaNoue & Roter, 2018; Wittenberg et al., 2021). Therefore, clinical empathy would become a new concept entering into the medical practice as part of the conceptual medicalization domain.

Interactional Medicalization. The patient and physician are the main individuals that work together to help accomplish a healthcare goal; those goals are also acquired by medical learners in medical school and residency and upheld through laws and policies created by organizations governing both groups (Cockerham, 2013; Maturo, 2012; Strauss et al., 2017). Furthermore, an argument can be made that the medical interactions can be perceived as positive or negative based on the individuals' communication skills, regardless of medical knowledge utilized during the interaction (Chidume et al., 2020; Cockerham, 2013; Finset, 2021; Mohd Hanafiah et al., 2021). Thus, interactional medicalization is the way in which medical care is

shaped by the social interaction and shared cultural norms established by the wants and needs of the patient, physician, and shift depending on medical knowledge, medical discoveries, and available resources (Conrad & Backer 2010).

In summary, there are many benefits of using the medicalization domains as a way of examining the types of communication used in healthcare. First, medical education informs professionals how to interact with patients. The interaction then leads to the patient's health decisions (Cockerham, 2013; Shapiro, 2008). Second, the evolving relation between institutional and conceptual medicalization regarding communication types explains the alignment of medical profession and patient care. Finally, positive clinical outcomes rely on the patient-physician relationship based on using various forms of communication that allow for shared knowledge and understanding in the clinical environment.

Proposed Conceptual Framework

The proposed medicalization framework used to include communication into medicine is presented in Figure 1.1 For the purpose of my research, the medicalization of communication will be illustrated through an examination of communication concepts, institutional policies, and interactions within medical education.

Figure 1.1

Medicalization of Communication Conceptual Framework
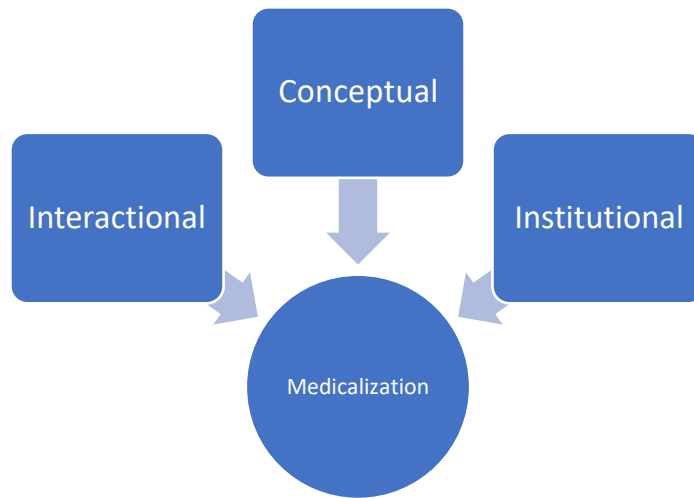
The model shows that all three domains constitute the medicalization concept. This framework will assist in exploring how communication is embedded in the medical field through a medicalization process and how it affects the medical profession, the medical learners (i.e., medical students and residents), physicians, and patients. Examining the policies, types of communication, and the training of physicians to become good communicators can demonstrate that communication has been medicalized in the most important areas of medicine and reinforced by the medical training of physicians.

Research Methodology

This article-based dissertation is guided by the medicalization framework and examines the communication phenomena in medical education policy, curriculum, and practices. The dissertation will be based on the presentation and analysis of three studies in which I have researched various communication elements that contribute to (and define) the concept of medicalization of communication. One study will focus on policies that support the medicalization concepts. The other two empirical studies focused on communication training

through a cross-discipline approach. Dissertation findings will be discussed in the context of proposed medicalization framework based on communication domains to establish the types of communication employed in the medical field.

First study presented in Chapter 2, focuses on policy, which is defined as an action taken by various stakeholders to deal with specific problems and aim to reach a common goal (Anyebe, 2018; Fowler, 2014). That action can be about rules, laws, regulations, or standards that dictate behaviors of individuals or groups (Fowler, 2014). Policy analysis evaluates the guidelines of an organization or group because those guidelines reflect the values of organization or group members (Anyebe, 2018; Fowler, 2014). For instance, the interaction between the patients and physicians requires a complex analysis. However, examining the policies and standards in medicine helps identify the types of communication needed for these interactions, based on the medical profession's shared goals and values.

Next two chapters are presenting the two quantitative research studies to gain an understanding of the patterns of communication interactions exhibited in medical education and/or medical practice (Dowson, 2019; Hoy, 2010; Tayur & Dai, 2018). Research on the communication interactions allows for an examination of the societal values and practices of a specific community (Barnham, 2015; Duckett, 2021).

Research Site and Population

The population from which data was collected consisted of medical learners from a Health-Related Institution (HRI) in the Southern United States. In the 1990s, HRIs were introduced to curriculum practices surrounding learning of communication skills. The development of the curriculum and practice guidelines is the result of partnerships among stakeholders such The American Medical Association (AMA), the Liaison Committee on

Medical Education (LCME) strive toward competency-based education regarding the physician-patient relationship (Drew & Thompson, 2005; Gambert, 2007; Lucey & Johnston, 2020).

The HRI practice is governed by policies created by national and international medical organizations. Therefore, governing bodies such as LCME, AMA, General Medical Council, Institute for International Medical Education, Accreditation Council for Graduate Medical Education, and the Health Insurance Portability and Accountability Act of 1996 contribute with public data for the policy article included in this dissertation.

Data Collection

The policy article is based on the analysis of documents that guide curriculum development. The data consist of information from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and organizations such as the American Medical Association, Institute for International Medical Education, General Medical Council, Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other organizations around the world that determined that communication is a necessary skill for physicians (Batalden et al., 2001; Donaldson, 2008; Eaglen, 2017; Friedmann & Leach, 1999; Macchie, 2009).

The second paper is based on survey data that identified levels of empathy after a communication workshop using the validated Jefferson Scale of Empathy (JSE). The JSE version used in this study was created for medical students and was used in this study to assess their clinical empathy levels. The survey data was collected from students who participated in a one-day workshop on communicating empathy. The survey first asked the students their age, gender, year in medical school, and specialty interest. The specialty interest was classified into three categories depending on the degree of patient engagement: people-oriented, procedure-

oriented, or other-oriented. The 20 survey items were measured on seven-point Likert scale where the participants rated how much they agreed or disagreed with each statement involving empathy. For analysis, the statements were organized into three scales: perspective taking, the compassion of care, and walking in a patient's shoes. The respondents had to answer all the questions to be included in the data analysis.

The third paper is based on a second survey that examined the communication training and experience of medical residents. This is an internal survey developed by HRI. The survey starts by asking year in residency, and gender. Then, using a five-point Likert scale with response ranges from never to always and strongly disagree to strongly agree, the residents were asked 22 questions involving patient communication. For the study, selected survey items are used to describe residents' perceptions of preparedness in having goals of care discussions, as well as the perceived effectiveness of having goals of care discussions after a communication training. The respondents had to answer at least 80% of the questions to be included in the data analysis.

The two empirical studies examine types of communication that benefit the patient-physician relationship based on self-reported skills. The two quantitative articles used The Statistical Package for the Social Sciences (SPSS) to conduct descriptive statistics and comparative analysis of the data. All student information was deidentified in the survey data and the documents for the policy analysis were public information; thus, the corresponding educational institution waived the IRB (see appendix A) for all three studies.

The Studies

This dissertation examines the policy, curriculum, and practices involving communication training offered to medical learners through a policy analysis study introduced in

Chapter 2, and two empirical studies presented in Chapters 3 and 4. The articles are relevant to the field of medical communication education in the United States and represent an application of communication principles and values within the medical field. The policy analysis and empirical studies are in various stages of publication, but all have been or will be presented as papers at regional and national conferences. One paper has been also published,

1. Dorough, R. (October 2021). *Miscommunication in Healthcare Policy Analysis*: *An Evaluation of Policies and Competencies Related to Teaching Medical Education Communication*. Paper presentation accepted at the 2021 Assessment Institute Annual Meeting. Virtual. Submitted and under review for publication in the *Southern Communication Journal.*

2. Dorough, R., Siropaides C., & Trache, M. (December 2021). *Association of medical student characteristics and empathy after a communication workshop. Journal of Patient Experience.* Article first published online: December 13, 2021; Issue published: January 1, 2021. https://doi.org/10.1177/23743735211065273

3. Dorough, R., & Siropaides, C. (June 2021). *Medical Learners' Perceived Effectiveness in the Communication Skills Needed to Conduct Goals of Care Discussions*. Paper Presentation presented at the 11th Annual Association for Assessment of Learning in Higher Education Annual Conference 2021. Virtual.

The purpose of the policy analysis is to examine the communication standards across accreditation agencies among medical learners and the ethical practice requirements of physicians in relation to communication. The documents analyzed are The Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Medical Association (AMA) reports and Code of Ethics, the Entrustable Professional Activities Standards, Liaison Committee

on Medical Education (LCME), and the United States Medical Licensing Examination regarding the Step 2 Clinical Skills examination. The policy analysis examines aspects of communication needed in medical education to optimize physician-patient interactions using the medicalization framework.

The second article focuses on the need for empathic communication in training medical students with specific specialty interests. This type of empathetic communication can be measured using the Jefferson Scale of Empathy (JSE) that examines three parts of empathetic traits: being able to walk in a patient's shoes, interacting with patients compassionately, and understanding a patient's perspective when creating care options. The JSE was used pre- and post-workshop on communication skills for a sample of over 100 medical students. This is a quantitative study using ANOVA analyses to examine the effect of gender and medical specialty on participants' response to the communication intervention (i.e., workshop training).

The third article reviews residents' comfort levels regarding the communication skills needed in patient interactions by exploring medical learners' perceived communication effectiveness in conducting patient goals of care (GOC) discussions. A sample of 114 residents in either their first, second, or third year of residency was surveyed before and after a communication training. This quantitative study employs multivariate analyses to examine residents' perception of preparedness as defined by effectiveness of care, confidence in having GOC discussions with patients, confidence in making recommendations that align with patient values, and the perceived value of GOC training.

Limitations of the Studies

First, the data was collected from a single research institution situated in the southern United States, so findings cannot be generalized to any public health institution. Second, the data

was collected through a voluntary survey and is susceptible to bias. The results reflect participants' beliefs and behaviors at one specific time and only immediately after receiving the training, so different outcomes could have been obtained if done over a more extended period. Third, the policy analysis assumes that policy reflects the values of the medical community. However, policy removal can be perceived as allowing individuals in the medical community to customize practices for their needs and not as a devaluation of a phenomenon. Finally, none of the studies has the perspective of physicians, patients, or clinical stakeholders.

Significance of the Research

Medicine is constantly evolving. As new technology and resources come available, changes in medical education will be necessary and understanding the types of communication involved in the process of delivering medical support to the public has the potential to increase the level of shared decision-making in physician-patient relationships.

First, this research will contribute to better understanding these complex relationships and how communication policy and practices intertwine in preparing physicians. This information is particularly valuable to policymakers when deciding the educational and ethical requirements of the physician profession.

Second, communication is the tool to help physicians and patients have a shared understanding of the medical decision-making (Germaine et al., 2021; Harrington et al., 2020; Mohd Hanafiah et al., 2021; Ranjan et al., 2015; Wittenberg et al., 2021). How physicians communicate medical knowledge is essential in the decision-making for themselves and their patients. The interaction binds both the physician and patient, regardless of knowledge. That interaction involves the resources of the physician, such as education, trust, empathy, and interpretation from the patient to create a shared decision about medical care. That interaction is

based on physician's communication skills, and their acquisition depends on the policies put in place by profession and taught to medical learners. Therefore, this study is significant to physicians and medical learners to know what types of communication benefit the clinical environment and should be established early within education and training.

Third, research on the types of communication needed in medicine will inform medical school administrators, policymakers, and physicians on implementing communication practices within the curriculum that prepare the kind of physician for the community they are serving. Thus, communication can be customized by institutions and medical specialties, depending on each medical field's transformation and the mutually beneficial needs of future physicians.

Finally, this dissertation will demonstrate that an interprofessional approach may be needed to address issues involving communication in medicine and such approach should include perspectives from other fields such as social sciences and humanities. Researchers from various disciplines will benefit from seeing how this interprofessional approach brings together concepts, policies, and practices from different fields like healthcare policy, communication, and medical communities within individual medical specialties. Furthermore, we are all a part of the health care community, whether we are healthcare workers, caretakers, or individuals advocating for our care, and we all contribute to the overall understanding of health.

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CHAPTER 2

MEDICALIZATION OF COMMUNICATION:

AN EXAMINATION OF COMMUNICATION POLICIES IN MEDICINE[1]

Medicalization was initially defined as making something medical (Clarke & Shim, 2011; Conrad, 1992; Parens, 2013). However, the idea has expanded from defining and researching diseases to including how medical problems are addressed by society (Clarke & Shim, 2011; Conrad, 1992). Medicalization theory also examines the evolution of the patient and physician communication, which is the focus of this article (Clarke & Shim, 2011; Cockerham, 2013). In this context communication is defined as a "meaning exchange between two or more people (or, to be precise, two animate beings). For this exchange to occur, there has to be expression and interpretation of meaning" (VanPatten, 2016 p. 2). Communication interaction has developed as an essential part of medical education since the 1990s, with establishing rules and guidelines through accreditation standards and learning competencies (Friedmann & Leach, 1999; Macchie, 2009; Swing, 2007). The research on the patient-physician relationship shows that positive interaction leads to increased patient compliance and a decrease in the barriers experienced by physicians, patients, and healthcare teams (Kachalia et al., 2018; Mohiaddin et al., 2019; Suojanen et al., 2018b).

Policies and standards regarding communication are present in multiple areas of a physician's job, including ethical expectations, health information, and medical education. Developing communication skills to interact with patients and healthcare teams has continued to be one of the main topics of discussion within medical education, a trend that has intensified

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over the past few years (Harrington et al., 2020; Spagnoletti et al., 2018; Wittenberg et al., 2021).

Although communication is not about a disease to be named, or a specific medical problem, the

concept is continuously reconstructed and redefined to be utilized for better care. This paper uses

policy as evidence to demonstrate that interaction between physicians and patients is an essential

part of the medical community communication practice, and thus it has become part of

medicalization. Examining the medical profession's standards from a policy perspective will

demonstrate that the medicalization of communication is a main concept in the medical

community, and an integral part of physician practice and education.

Policy Examination

The patient and physician relationship has changed, since initially, doctors treated

patients based on personal experience and trial and error (Bayne, 2011; Betancourt et al., 2013;

Cegala & Lenzmeier Broz, 2002). Today, there are multiple stakeholders in the medical process

besides just the patient and physician, including insurance companies, the health system, and

employers. Medicalization of communication frames the requirements in medical education as an

integrated part of what defines the successes of physicians (Cockerham, 2013). Examining policy

is a way to discover innovations, adaptation, and implementation within any industry (Fowler,

2014). Fowler (2013) describes a policy issue as a process during which governing bodies come

together to make rules, laws, standards, and policies to address the problems shared by

individuals and the groups they serve. The policy development includes the following steps:

identifying a solution to a problem, the creation of policy, adaptation, implementation, and

finally, the evaluation, which describes the examination of the policy from the issue that led to

the need for change (Fowler, 2014). Examining the policies and standards regarding ethics,

privacy, and medical training establishes that the medical community has determined that communication is important in medicine (Fowler, 2014; Smith & Larimer, 2009).

Medicalization of Communication

Medicalization dates back to Pitts' (1968) sociological view of creating "effective means of social control" when redefining certain aspects of deviant behaviors as being determined by social structures. The concept has been expanded by including technology means in medicine and all stakeholders that influence the medical process (Pitts, 1968). Due to technological advancement, the concept has widened to include patients as consumers who can acquire more knowledge due to technology (Clarke & Shim, 2011). Debate exists on whether biomedicalization theory is an expansion of medicalization or a subset of it (Clarke & Shim, 2011; Cockerham, 2013; Conrad, 1992; Parens, 2013). This paper will examine communication education in the medical field, with or without technology, using the original concept of medicalization. The policies involving communication embedded in the practices and education of physicians will allow for an examination of medical practice, using the medicalization theory.

Medicalization of Communication: Ethics and Privacy

As more stakeholders from insurance and pharmaceutical companies, and the government become involved in medicine, the importance of communication can affect the lives and livelihood of patients and physicians (Clayton et al., 2013; Parens, 2013). However, the current conversation is beyond the clinical environment. Doctors are no longer the neighbors next door who have known their patients for years; they are part of a regulated, more extensive system (Cockerham, 2013; Ferreira-Padilla et al., 2015; Foucault, 1973; Lucey & Johnston, 2020; Suojanen et al., 2018a). As a result, their practice is highly regulated.

The American Medical Association (AMA), founded in 1847, established the Code of Medical Ethics, a changing document that guides physicians worldwide (Gambert, 2007). The document related to communication has changed from just offering guidelines to consent and decision making to aspects of electronic communication with patients, even including how to conduct oneself on social media, television, and in political conversations while practicing medicine (Gambert, 2007). The AMA's original stance has been to stay out of politics and to treat the individual, although during the COVID-19 pandemic, scholars have changed their opinions on how physicians' communication should be transparent in breaking down myths from social media (Mohd Hanafiah et al., 2021). Ethical principles are guidelines for physicians, but privacy is a law and regulation that involves communication. Another element of privacy is the ongoing conversation on the role communication plays in the patient-physician relationship through the privacy act.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has strict guidelines on the health activities, such as how individuals are treated, what information can be used and disseminated for research, education, and treatment (HIPAA, 1996). In addition, HIPAA created national standards for apps, websites, and other electronic health care interactions. Finally, the act guides the communication areas mentioned above for physicians and provides guidelines for different stakeholders, such as insurance companies, employers, medical staff, hospitals, clinics, and pharmacies (HIPAA, 1996). This internal and external regulation ties back to the medicalization of the communication process in medicine. Moving from the ethics and privacy issues to education shows the different types of communication valued in education, beyond protection and privacy aspects.

Medicalization of Communication in Education

Medical education goes through continuous changes to keep up with pressures from patients, governing bodies, and the workforce to produce physicians who have effective medical skills in their field and possess interpersonal skills to serve varying populations (Caverzagie et al., 2017). The policies in education can be argued to be among the most critical elements of medicalization. Good medical training increases the likelihood that doctors provide the care needed for the community and individuals they treat (Brem et al., 2021; Caverzagie et al., 2017; Manyuk, 2016; Wittenberg et al., 2021). The examination of policies focuses on the alignment of different stakeholders' shared goals. Caverzagie et al. (2017) state, "These oversight bodies evolve by implementing new policies and processes that support and maintain the professional mission of educating a workforce capable of caring for patients and populations" (p. 591). Therefore, examining the educational policies is essential to understand what is necessary to all stakeholders involved in the medical education process. In the next section, I will be reviewing the medicalization of communication standards in medical school and residency from a policy perspective.

Standards in Medical Schools

Groups such as the Liaison Committee on Medical Education (LCME) create policies and accreditation standards in medical education that reflect the values of the medical community. The organization is the governing accrediting body for all medical institutions, because without graduating from an accredited institution, a physician cannot be licensed in the United States. The LCME secretary stated that external influences requested "more information on how students are prepared to communicate with culturally diverse populations, and the other was the adequacy of patient resources for medical student education" (Eaglen, 2017 p. 162).

Medicalization of communication requires a shared motivation and joint actions of all groups involved such as physicians, patients, students, and external stakeholders such as insurance companies.

Examination of Communication Skills

The United States Medical Licensing Examination (USMLE) examined reports and research created by the American Medical Association, Institute for International Medical Education, General Medical Council, Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other organizations around the world that deemed that communication was a necessary skill for physicians (Batalden et al., 2001; Eaglen, 2017; Friedmann & Leach, 1999; Macchie, 2009). As an example, the Association of American Medical Colleges states that "the ability to communicate effectively, both orally and in writing, with patients, patient's families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities" (Puchalski et al., 1999 p. 3). These reports led the USMLE to require that the testing of clinical interactions includes both verbal and nonverbal communication skills, and English proficiency. The skills tested, based on the Institute for International Medical Education communication recommendations and other reports, included objectives such as:

- "Listen attentively to elicit and synthesize relevant information about all problems and understanding their content

- Apply communication skills to facilitate understanding with patients and their families and to enable them to make decisions as equal partners

- Demonstrate sensitivity to cultural and personal factors that improve interactions with patients and the community

- Communicate effectively both orally and in writing

- Synthesize and present information appropriate to the needs of the audience, and discuss achievable and acceptable plans of action that address issues of priority to the individual and community" (Stern et al., 2003 p. 4)

All medical institutions officially assessed communication skills and practices in the United States, the United Kingdom, and India, based on the U. S. reports. Thus, making the examination of the educational standards in the American medical school system an important aspect to medicine in multiple countries.

<center>**Factors in the Dismantlement of the STEP 2 Clinical Skills Examination**</center>

The STEP 2 Clinical Skills (CS) Examination was one of the only examinations that evaluated communication skills in medical school. The examination consisted of students taking a patient's clinical history while being observed and evaluated on communication skills. As a result, curriculum instructors in medical education became experts in the new way of using simulation to evaluate students' skills (Baker, 2021; Howley & Engle, 2021; Katsufrakis & Chaudhry, 2021). The STEP 2 CS examination was recently put on hold because of the pandemic and eventually discontinued (Fatima et al., 2021a; Yudkowsky & Szauter, 2021). The changes that led to eliminating the Step 2 CS examination are the results of a larger shift in policy in medical education. Although research shows that physicians are divided about the changes in the clinical skills examination, Fowler (2013) explains that differences are usually based on economics, demographic trends, or ideological shifts that are discussed in this section.

Economic Reasons

The first factor to examine is the economic challenge of the USMLE STEP 2 Clinical Skills examination. Since the early 2000s, national surveys have shown that medical students

have called for eliminating STEP 2 CS. Then, a group of over 17,000 physicians and students

signed a petition to stop the examination because they felt that it would reduce cost without

having an adverse effect on the care of patients (Ecker et al., 2018). Data shows the examination

cost for students adds up to over $20 million and does not include the expenses of taking the

examination (Ecker et al., 2018).

Demographic Reasons

Demographic trends are another factor that Fowler (2013) establishes as affecting the

direction of policy changes. The current trend of telemedicine and training communication skills

based on the institutions' demographics are all factors not considered in the examination content.

As a result, the educators do not all believe the feedback provided is helpful, and there is no

unified definition or metric to evaluate the acquisition of communication skills (Humphrey et al.,

2020; Kaplan-Liss et al., 2018; Katsufrakis & Chaudhry, 2021; Yudkowsky & Szauter, 2021).

Diversity in care and the need to decrease health disparities have created multiple

communication techniques for effective communication. Since the implementation of the

examination, a large amount of research has been done that shows that medical schools have

lacked communication skills related to empathy and creating care goals for patients (Chidume et

al., 2020; Fatima et al., 2021a; Lee et al., 2018; Mohiaddin et al., 2019). Placing the

responsibility of communication back on the individual institutions allows for a customized

learning experience.

Communication Ideology

Medical communication was seen as a natural gift that cannot be taught (Ranjan et al.,

2015). However, Kwong (2017) argues that an ideological shift has occurred as communication

education has become more popular. A crisis such as COVID-19 pandemic has shown the

relevance of empathetic communication to help communities trust medical information (Mohd Hanafiah et al., 2021). It has shown that overcoming health challenges as a community requires various strategies of communication to engage individuals across different social classes, religions, and socioeconomic statuses (Mohd Hanafiah et al., 2021). As suggested by Mohd Hanafiah et al. (2021), "building trust and harnessing transdisciplinary voices that deliver clear, empathetic, and actionable messages using effective communication tailored for different purposes and audiences is critical for prevention and control of future viral diseases . . . " (p. 12).

Since the creation of the clinical skills examination, experts have been trained to teach communication skills to medical learners. Yet, the lack of value and efficiency is one of the reasons for the elimination of skills examination (Ecker et al., 2018). Even if it had limited efficiency, the USMLE Step 2 Clinical Skills examination was the only licensing examination that evaluated and assessed clinical skills leading to a medical license (Fatima et al., 2021a, 2021b; Yudkowsky & Szauter, 2021).

Standards in Residency: Filling the Gap Between Medical School and Residency

LCME not having specific outcomes led to the creation of Entrustable Professional Activities (EPAs), needed to reduce a gap that existed between medical school and residency (Angus et al., 2017; Englander et al., 2016; Sebok-Syer et al., 2021; ten Cate et al., 2021). The creation of these policies was to ensure that all medical students could perform a particular task before starting a residency program (Englander et al., 2016). The EPAs led to faculty and student training in outcomes that needed to be achieved to become a physician and was achieved by shifting toward competency-based education (Schumacher & Turner, 2021). Before the EPAs were established in 2013, clinical skills evaluation was not required (Englander et al., 2016; Schumacher & Turner, 2021). The EPAs have set forth thirteen standards for the successful

completion of a medical degree. Table 2.1 identifies eight of the thirteen EPAs standards that

insert a communication element into the medical educational process (Englander et al., 2016 p.

1354). The other five standards that indicate clinical capabilities are not directly related to

communication skills.

Table 2.1

Entrustable Professional Activities Standards

Standards involving communication	Noncommunication standards
Gather a history and perform a physical examination	Document a clinical encounter in the patient record
Prioritize a differential diagnosis following a clinical encounter	Identify system failures and contribute to a culture of safety and improvement
Enter and discuss orders/prescriptions	Recognize a patient requiring urgent or emergent care and initiate evaluation and management
Provide an oral presentation of a clinical encounter	Perform general procedures of a physician
Form clinical questions and retrieve evidence to advance patient care	Recommend and interpret common diagnostic and screening tests
Collaborate as a member of an interprofessional team	
Obtain informed consent for tests and/or procedures	
Give or receive a patient handover to transition care responsibility	

Although the LCME has discontinued the clinical skills examination, communication

competency is still closely tied to the medical degree and profession. EPAs provide guidelines

for medical educators to assess the clinical skills of medical learners (Schumacher & Turner,

2021; Sebok-Syer et al., 2021). Sebok-Syer et al. (2021) describe the combining of medical

education and patient outcomes as an ongoing development by stating, "If we remain cognizant of the triad of interdependence, foreground the patient when possible, and consider shared foregrounding when appropriate, we can move one step closer to the desired goal of linking educational outcomes with patient outcomes" (p. S80). In addition, the EPAs provide transparency to all participants involved and thus lead to more clear objectives for the learners and educators (Angus et al., 2017). The EPAs are creating an evidence-based educational system within medicine that allows medical schools to decide what to teach to ensure that the medical learners are ready to interact with other healthcare professionals and the patients (Angus et al., 2017; Macchie, 2009; Sebok-Syer et al., 2021; ten Cate et al., 2021).

Communication and the Future of Medical Education

Future responsibilities of the schools versus the governing agencies are always a debate in policy analysis. A critical component to policy analysis is the inclusion of all stakeholders (Fowler, 2014). The patient or public is not informed of the removal of the examination and its potential impact on communication. With the outcry on how to get through to the public regarding health issues, there might be a need for input from the public from a policy analysis perspective.

By not requiring the STEP 2 Clinical Skills examination can allow to develop population-based initiatives in teaching how to communicate with patients while taking some financial burden off universities and students (Fatima et al., 2021a; Mohd Hanafiah et al., 2021). Assessment and evaluation will look different although may cause innovation in some areas and deficits in others (Baker, 2021; Morrison et al., 2020). What we do know is that "clinician communication is a vital part of the patient experience and can shape medical decisions that alter the trajectory of care" (Siropaides, 2018 p. 3). Future research will determine if the deregulation

of communication in medical education will be a good thing. Therefore, research on what type of communication is necessary becomes an important way moving forward. The EPAs may be enough to guide medical schools to prepare residents interact with patients and other healthcare teams (Rider et al., 2006; Rider & Keefer, 2006; Yudkowsky & Szauter, 2021).

Implications and Complications

The risk of eliminating the clinical skills examination is that schools will have less incentive to teach communication skills in medical education. Communication is changing quickly in medical education. For example, most research on medical communication is based on face-to-face interactions, which has led to issues with the COVID-19 pandemic and the limited face-to-face interactions. Virtual communication research is the future of medicine and will impact the interaction of society and physicians (Finset, 2021). The communication needed will more than likely require different strategies. A challenge may be created in for new residents, with medical students not being ready to communicate (Baker, 2021; Howley & Engle, 2021; Stern et al., 2003). Research already shows a clear gap in communication in medicine, but alternatives have been suggested (Fatima et al., 2021a; Katsufrakis & Chaudhry, 2021; Morrison et al., 2020; Yudkowsky & Szauter, 2021). The creation and adaptation of the clinical skills examination is not the end of communication practice in medicine. Eliminating the clinical skills of USMLE may be caused by the culture shift that communication is already ingrained in medical education. Although changes are happening in medical education, the one element that remains stable is that communication is an integral part of the future of medicine.

Recommendations

This policy analysis suggests the need to examine the disparities highlighted during the pandemic and engage in a collaborative effort to develop new communication standards that are comprehensive in medical school and residency. Individual and institutional assessment is the next step for communication education in medical schools. The future of communication in medical education should incorporate experts in public health, sociology, education, communication, and other societal stakeholders to provide the medical profession with the tools to communicate health information to the diverse public. The top-tier medical journals should also invite scholars in other fields to provide cultural awareness to communication practices.

Conclusion

Fowler (2013) reinforces the benefits of multiple agencies and groups coming together to adopt a policy. The same approach should be used to ensure equity in healthcare communication to and about patients. The medicalization of communication will evolve, and the physician-patient interaction will become a monitored phenomenon using technological advancements. Examining medical education from a cross-disciplinary perspective allows for different types of innovation to be considered to benefit every doctor, medical student, and patient. After reviewing the policies, the medicalization of communication research should lead to creating the interpersonal, professional, and intercultural communication types that make up medicine beyond the mere interactions with patients.

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CHAPTER 3

ASSOCIATION OF MEDICAL STUDENT CHARACTERISTICS AND EMPATHY AFTER

A COMMUNICATION WORKSHOP[2]

Clinical empathy research has shown that the ability for healthcare professionals to create interpersonal relationships with patients is beneficial (Jordan & Foster, 2016; Ranjan et al., 2015; Stansfield et al., 2016). Consequently, medical education has shifted focus to a patient-centered approach that includes responding to patient's emotions, validating concerns, offering support, and developing a partnership for treatment planning (Broukhim et al., 2019; Helen Riess, 2017; Marathe & Bansal, 2018). Developing empathy is key to recognizing patients' emotions and has even become a goal of medical education recognized in licensures and medical education policies put in place by agencies such as the American Association of Medical Colleges (AAMC) (Smajdor et al., 2011; Vinson & Underman, 2020). Yet, focus on empathy in medical education programs is still in the early stages and there is little guidance on how to teach, evaluate, convey, and even define empathy in medical contexts (Hojat, 2016; Hojat et al., 2018; Piumatti et al., 2019). In response to this need, the Jefferson Scale of Empathy (JSE) was developed and became a widely used instrument to evaluate empathy in medical contexts (Hojat et al., 2001). The importance of teaching communication in the medical field derives from the need to enhance medical personnel's capacity to provide accurate information to patients in a manner that demonstrates care and concern for others and encourages the practical use of empathy within patient-clinician relationships (Hall & Schwartz, 2019; Neumann et al., 2009; Ranjan et al., 2015; Sulzer et al., 2016).

Healthcare professionals must balance the communication of objective medical information while also maintaining empathy and readily responding to patient emotions (Neumann et al., 2009; *Palliative Care in Nephrology*, 2020; Scheunemann et al., 2012; Stansfield et al., 2016). Physicians need effective skills of expressing empathy that shows understanding, respect, and support to empower patients to make informed decisions (Suojanen et al., 2018; Zwingmann et al., 2017). Empathy creates emotional space to allow patients to evaluate their values and motivation for treatment (Hall & Schwartz, 2019; Ramirez et al., 1995; Zwingmann et al., 2017). On the contrary, lacking empathetic communication skills decreases the patient satisfaction and can lead to burnout in physicians (LaNoue & Roter, 2018; *Palliative Care in Nephrology*, 2020; Sulzer et al., 2016).

Patient-centered care should prepare health professionals to be empathetic and to effectively communicate empathy (Boissy et al., 2016; Kaplan-Liss et al., 2018; LaNoue & Roter, 2018). Communication refers to a shared interpretation of meaning (Shapiro et al., 2004). Empathy, in this case clinical empathy, goes beyond a shared understanding and focuses on the actions of the health professional to interpret what a patient is feeling and validating through communication an understanding to the patient (Hojat et al., 2001). Communication of healthcare information with explicit acknowledgment or consideration of the patients' emotions is more effective in a clinical setting than that without expressions of empathy (Hojat et al., 2018; Neumann et al., 2009). Since empathy is a part of the interpersonal skills needed to understand and interact with patients, several studies recognize empathy skills should be strengthened throughout medical training (Fernández-Olano et al., 2008; Riess, 2017).

A shared psychometric scale to measure empathy can help medical education be standardized with respect to developing recognition of emotion and expressing empathy. The present study

aims to understand if a 90-minute workshop given to medical students on how to recognize patient perspectives and utilize verbal expressions of empathy and exploration improves the medical students' level of empathy as measured by the Jefferson Scale of Empathy (JSE). Research demonstrates an interaction of gender and medical specialty on clinical empathy (Hojat et al., 2001). Hojat et al. discovered that students and physicians who identified as women scored higher on JSE (Hojat et al., 2018). Additionally, students in procedure-oriented specialties are more likely to show a lower JSE score (Fernández-Olano et al., 2008; Hojat et al., 2018; Hojat et al., 2001). To extend the scope of current research, we sought to examine the effect of a single workshop delivered to all learners on clinical empathy scores and any differences of that impact when considering gender and medical specialty.

Method

We conducted a workshop for pre-clerkship medical students to introduce and practice skills to acknowledge patients' emotions, and articulate verbal empathy as part of a required clinical skills curriculum at the University of Texas Southwestern Medical Center (18, 27). The students' self-reported empathy was evaluated before and after the workshop on the JSE according to specific measurements. The study was considered exempt by the appropriate institutional review boards.

Communication Intervention Workshop

The 90-minute workshop was delivered to all pre-clerkship medical students by faculty mentors responsible for all clinical skills curriculum delivery. Each mentor is matched with a small group of 6-10 students which remains consistent throughout their training. Faculty received one hour of training on the curriculum content and delivery of the workshop. Learners were assigned asynchronous pre-reading to review the effects of communicating empathy

(Schumacher & Turner, 2021). The workshop first introduced a case example of a patient presenting to discuss their laboratory results which requires a provider to "break bad news" of a new diabetes diagnosis. Faculty then reviewed a framework of various skills to express verbal empathy which includes naming emotion, understanding patient perspective, respecting patient experience, providing statements of support, and further exploring patient emotion (Katz, 2019). A brief scripted role-play was introduced, with faculty reading different patient responses to the news. The students were encouraged to recognize patient statements as emotional responses, and faculty then facilitated a repetitive drilled practice for students to deliver scripted phrases of verbal empathy in response to each patient statement.

The workshop concluded with a structured debrief of the experience. The repeated phrases used during the drills were developed using evidence-based methods of articulating empathy through validating and exploring patients' feelings (Hojat, 2016; Swenson et al., 2004; Zwingmann et al., 2017).

Research Sample

The sample consisted of 116 pre-clerkship medical school students who participated in the communication training workshop as part of their standard clinical skills development curriculum. They voluntarily completed the pre- and post-survey assessments and opted for data inclusion. The participants were asked to identify their gender, medical school specialty or area of interest, and year in medical school. Fifty-eight of the students identified as male and 58 as female. The students were given the option to select a gender based on their own determination. The specialties consisted of 23 primary selections with 18 sub-selections. Those selections were then categorized and broken into three areas previously established by research related to the Jefferson Scale of Empathy. The areas are Procedure-oriented, People-oriented, and Other. As

described in the literature, the people-oriented specialties focus more on long term care, such as general internal medicine, family medicine, pediatrics, and psychiatry (Hojat et al., 2001). The Procedure-oriented specialties focus on diagnostic or technical procedures and usually do not require long term care of patients; some examples are surgery, radiology, and pathology (Hojat et al., 2001). The Other specialties do not fit into a specific category as it relates to patient-clinician relationships and can have traits of both procedure- and people-oriented specialties, such as dermatology and emergency medicine (Fernández-Olano et al., 2008; Hojat et al., 2018; Kaplan-Liss et al., 2018). The classification was established and supported by existing literature utilizing the Jefferson Scale of Empathy (Fernández-Olano et al., 2008; Hojat et al., 2018; Hojat et al., 2001). Table 3.1 describes the distribution of the sample by gender and specialty.

Table 3.1

Descriptive Statistics of the Sample

Specialty Groups	Gender	
	Male	Female
People-oriented (specialty focus on long term care, like family medicine and pediatrics)	13	22
Procedure-oriented (diagnostic/technical and do not usually include continuous care of patients)	21	9
Other (combination of both procedure- and people-oriented specialty characteristics)	24	27

Instrument: Jefferson Scale of Empathy (JSE)

The JSE version created for medical students was used to assess participants' levels of empathy pre- and post-workshop. The JSE is a psychometric instrument of 20 questions, based on a seven-point Likert scale. Higher scores indicate higher levels of empathy, and two items required reverse scoring statements. The JSE contains three categories of questions within the

20-question survey (Hojat et al., 2001). The first category indicates the clinician's *Perspective taking* which is the ability to see patients with empathic concern and dutifulness (Hojat et al., 2018; Hojat et al., 2001). Second is *Compassionate care*, which involves being empathetically concerned, having faith-in-people, displaying tolerance as well as self-protection, all while maintaining clinical neutrality (Hojat et al., 2001). Lastly is *Walking in a patient's shoes* and seeing how their environment, social, and physical attributes affect their lifestyle. All these components involve verbal and nonverbal communication from both the patient and medical professional which may be exerted at different levels.

Data Analysis

Composite scores were computed as the means of the corresponding JSE items for each of the three psychometric scales. The reliability of the three scales was calculated based on the pre-workshop results. Cronbach's alpha coefficients were .794 for the Perspective talking scale; .727 for the Compassion of care scale; and .737 for the Walking in a patient's shoes scale. The three psychometric scales are the dependent variables in the study while gender and medical specialty are factors. We then conducted a series of mixed ANOVA analyses to determine the change in empathy after workshop (time as within-subjects factor), the main effects for gender and medical specialty (between-subjects factors), and their interaction with the workshop intervention described as time.

<div align="center">

Results

</div>

Gender Effects

Mixed ANOVA analyses were conducted to assess the effect of gender on the three psychometric scales between pre- and post-workshop. Table 3.2 presents descriptive statistics

comparing pre- and post-workshop mean scores by gender. Then we present the results of the

ANOVA analyses for the three JSE scales.

Table 3.2

Descriptive Statistics of JSE Scales by Time and Gender

Variables	Male (N=58)		Female (N=58)	
	Mean	SD	Mean	SD
Perspective Taking Pre	5.86	0.69	5.99	0.59
Perspective Taking Post	5.98	0.76	6.15	0.58
Compassion Care Pre	5.78	0.69	6.10	0.64
Compassion Care Post	5.86	0.86	6.18	0.70
Walking in a Patient's Shoes Pre	4.04	1.43	4.41	1.13
Walking in a Patient's Shoes Post	3.91	1.50	4.52	1.39

Perspective Taking. There was no significant interaction between gender and time, $F(1, 114) = .223$, $p = .638$. There was however a significant main effect for time, $F(1,114) = 20.585$, $p <.001$, with both gender groups showing an increase in empathy scores after workshop. The gender effect was not significant, $F(1, 114) = 1.683$, $p = .197$ although females scored higher than their male counterparts.

Compassion of Care. There was no significant interaction between gender and time, $F(1,114) = .000$, $p =.995$. There was no significant main effect for time, $F(1, 114) = 3.226$, $p = .075$, with both gender groups showing an increase in empathy scores after the workshop. The gender effect was significant, $F(1, 114) = 6.585$, $p = .012$, women scored higher than their male counterparts at both times.

Walking in a Patient's Shoes. There was no significant interaction between gender and time, $F(1, 114) = 1.628$, $p = .205$. There was no significant main effect for time $F(1, 114) = .01$, $p = .895$, with only the female gender group showing an increase in empathy scores after the

workshop. The gender effect was significant, $F(1, 114) = 4.296$, $p = .040$, women scored higher than their male counterparts.

Medical Specialty Effects

A similar analysis was conducted to assess the effect of medical specialty on empathy scales before and after the workshop. Table 3.3 shows descriptive statistics comparing pre- and post-workshop mean scores by medical specialty. Then we present the results of the ANOVA analyses for the three JSE scales.

Table 3.3

Descriptive Statistics of JSE Scales by Time and Specialty

Variable	People-Oriented (N=35)		Procedure-Oriented (N=30)		Other (N=51)	
	Mean	SD	Mean	SD	Mean	SD
Perspective Taking Pre	5.98	0.63	5.86	0.84	5.92	0.51
Perspective Taking Post	6.20	0.58	5.95	0.95	6.05	0.54
Compassion Care Pre	6.15	0.59	5.80	0.75	5.88	0.68
Compassion Care Post	6.32	0.64	5.81	0.74	5.94	0.88
Walking in a Patient Shoes Pre	4.46	1.20	4.17	1.49	4.10	1.25
Walking in a Patient Shoes Post	4.47	1.55	4.32	1.56	3.97	1.35

Perspective Taking. There was no significant interaction between medical specialty and time, $F (1, 113) = 1.361$, $p = .261$. There was however a significant main effect for time, $F (1,113) = 19.875$, $p < .001$, with all specialty groups showing an increase in empathy scores after the workshop. The specialty effect was not significant, $F (1, 113) = .672$, $p = .513$ although people-oriented specialty scored the highest.

Compassion Care to Patients. There was no significant interaction between medical specialty and time, $F (1, 113) = 1.009$, $p = .386$. There was no significant main effect for time, $F (1,113) = 3.049$, $p = .084$, although all specialty groups showed a slight increase in empathy scores after the workshop. The specialty effect was not significant, $F (1, 113) = .672$, $p = .513$ although people-oriented specialty scored the highest.

Walking in Patient's Shoes. There was no significant interaction between medical specialty and time, $F (1, 113) = .662$, $p = .518$. There was no significant main effect for time, $F (1,113) = .015$, $p = .903$, with all specialty groups showing an increase in empathy scores after the workshop except for the category of other, which scored lower. The medical specialty effect was not significant, $F (1, 113) = 1.175$, $p = .312$ although people-oriented specialty scored the highest.

Gender and Medical Specialty Effects

In this section we will examine the changes in empathy scores over time at the intersection between gender and medical specialty. Similar mixed ANOVA analyses were conducted to assess the effect of gender-specialty groups on the three psychometric scales between pre- and post-workshop time. The six gender-specialty groups correspond to: male people-oriented, male procedure-oriented, male other, female people-oriented, female procedure-oriented and female other. Table 3.4 presents descriptive statistics comparing pre- and post-workshop mean scores by gender-specialty groups. Then we present the results of ANOVA analyses for the three JSE scales.

Table 3.4

Descriptive Statistics of JSE Scales by Time and Gender-Specialty Groups

Variable	Male People-oriented (N=13)	Male Procedure-oriented (N=21)	Male Other (N=24)	Female People-oriented (N=22)	Female Procedure-oriented (N=9)	Female Other (N=27)
Perspective Taking Pre	6.02	5.69	5.92	5.96	6.28	5.93
Perspective Taking Post	6.24	5.79	6.02	6.17	6.33	6.07
Compassion Care Pre	6.08	5.70	5.68	6.19	6.06	6.05
Compassion Care Post	6.21	5.76	5.75	6.39	5.93	6.10
Walking in a Patient Shoes Pre	4.42	4.00	3.87	4.48	4.56	4.30
Walking in a Patient Shoes Post	4.19	4.14	3.54	4.64	4.72	4.35

Perspective Taking. There was no significant interaction between gender-specialty groups and time, $F (1, 110) = .604$, $p = .697$. There was however a significant main effect for time, $F (1,110) = 16.891$, $p < .001$, with all six gender-specialty groups showing an increase in empathy scores after the workshop. The gender-specialty effect was not significant, $F (1, 110) = 1.316$, $p = .263$. Interestingly, in people-oriented specialties males are scoring slightly higher than females while in procedure-oriented specialties, females are scoring higher than males.

Compassion of Care. There was no significant interaction between gender-specialty groups and time, $F (1, 110) = .600$, $p = .700$. There was no significant main effect for time, $F (1,110) = 1.815$, $p = .181$, with all six gender-specialty groups showing an increase in empathy scores after the workshop except for females in procedure-oriented specialty. The gender-specialty effect was not significant, $F (1, 110) = 2.451$, $p = .038$, but females are scoring higher than males in each specialty category.

Walking in Patient Shoes. There was no significant interaction between gender-specialty groups and time, $F (1, 110) = .826$, $p = .534$. There was no significant main effect for time, $F (1,110) = 0.004$, $p = .950$, with all gender-specialty groups showing an increase in empathy scores after the workshop except for males in people-oriented and other specialties. The gender-specialty groups effect was not significant, $F (1, 110) = 1.384$, $p = .236$, but females are scoring higher than males in each specialty category.

Figure 3.1 below shows a visual representation of the mean scores over time for each JSE scale by gender-specialty groups.

Figure 3.1

Change over Time of JSE Mean Scores by Gender- Specialty Groups
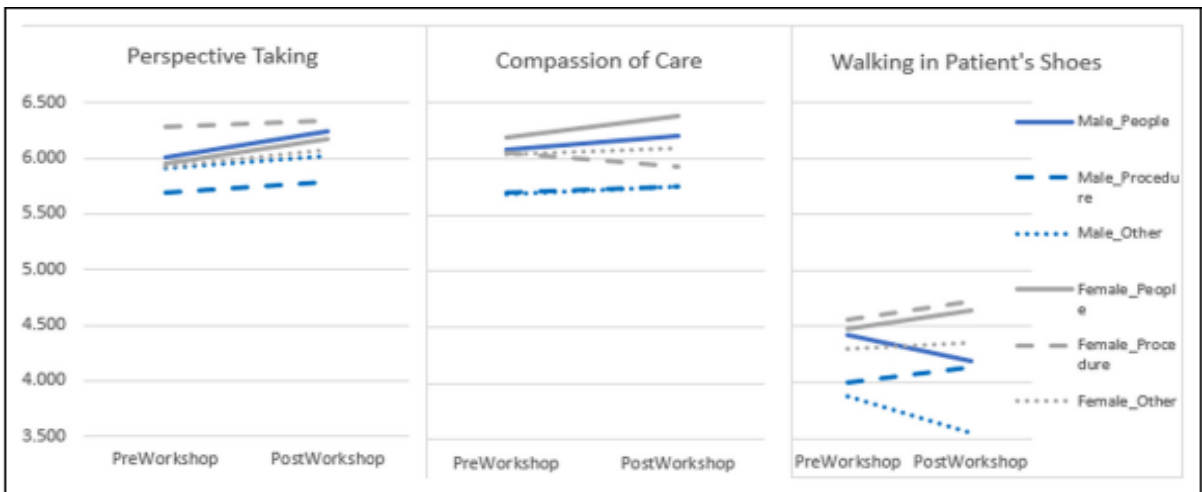
Discussion

The majority of JSE literature discuss specialty and gender independently as they relate to empathy. This study uniquely included interaction effects of specialty and gender subgroups within each empathy category of the JSE. The baseline data confirms most of the gender and medical specialty effects previously found in studies using the JSE instrument (Hojat et al., 2018; Hojat et al., 2001). In addition, we have uniquely identified that women in procedure-oriented specialty were the highest scoring subgroup in *Perspective taking* and *Walking in patient's* shoes

at baseline. A unique finding in this study was the relative low score of all students, regardless of gender and specialty, in the category of *Walking in a patient's shoes*. Conversely, the mean scores for *Perspective taking* and *Compassion of care* were significantly higher across all specialties regardless of gender. Overall, all gender-specialty groups improved in *Walking in patient shoes* except males in people-oriented and other specialties which actually showed a decrease in empathy after the workshop.

The findings suggest that curriculum development may need to be adapted to target learner's specialty of interest, highlighted by differences in workshop impact on people-oriented and other-oriented specialties and less notable impact on procedure-oriented specialties. This may reflect different learning styles, particularly given no significant difference in those groups at baseline.

Limitations

While a well-established validated instrument, the JSE relies on self-reporting that may influence participants to provide a more positive response in the post-test (Hojat et al., 2018; Hojat et al., 2001; Pollak et al., 2011). Additionally, the workshop is based on scenarios from clinical environments with which students may not have had adequate experience, and thus could affect scoring. Even with these limitations, the workshop shows promising benefits raising medical students' empathy awareness.

Implications

This study uses small interventions and gauges the empathy levels of medical students that allows for implementing change. This is an important step since other national studies found that a decline in empathy occurs for both students and residents as they go through schooling (Broukhim et al., 2019; Fernández-Olano et al., 2008; Hojat et al., 2018; Stansfield et al., 2016).

This study contributes to research suggesting that clinical empathy should be embedded in curriculum through diverse workshops that can be adjusted to the specific needs of the students. More research is needed to understand how empathy affects performance, trust, and self-efficacy within healthcare teams as medical students move into residency.

Conclusion

Healthcare professionals are expected to demonstrate empathetic concern, perspective taking, compassion, and understanding of patients. Research shows that higher levels of clinician empathy and patient-clinician communication skill training can improve patient satisfaction and reduce physician burnout (Boissy et al., 2016; Kaplan-Liss et al., 2018; Scheunemann et al., 2012). Communication training requires a multi-dimensional approach to target the various areas of building empathy; and as highlighted by this study, the impact of a curriculum can vary based on the participants demographic and medical specialty. Further research is needed to identify and optimize curricula for all medical students, regardless of gender and specialty. In addition, understanding deficits in domains of empathy allows communication training experts to focus on specific curriculum, and openly discuss and assess the issue throughout healthcare professionals' education and career (Bottino & Manji, 2020; VanPatten, 2016). Our study notes the lowest scores in *Walking in a patient's shoes*. Research shows courses in arts and humanities could have a greater impact on that domain (Pollak et al., 2011; Stansfield et al., 2016; Sulzer et al., 2016). Creating a cohesive, multi-faceted, and standardized communication training in medical education will have shared benefits for medical students, physicians and patients.

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CHAPTER 4

MEDICAL LEARNERS' PERCEIVED EFFECTIVENESS IN THE COMMUNICATION

SKILLS NEEDED TO CONDUCT GOALS OF CARE DISCUSSIONS[3]

Patient-centered communication requires medical personnel who possess skills such as empathy to understand the health goals and values of patients as to help them reach an agreement on recommended healthcare options (Dorough et al., 2021; LaNoue & Roter, 2018; Marathe & Bansal, 2018; Mott et al., 2021). Back et al. (2019) state that although communication has been proven to improve clinical outcomes, in some medical specialties there are up to 50% of physicians who do not receive evidence-based communication skills training. This lack of training is problematic because all medical learners are still expected to demonstrate effective clinical communication (Dowson, 2019; Germaine et al., 2021; Sagin et al., 2021; Suojanen et al., 2018). In particular, residents need the skills to communicate with patients about their prognosis and to adjust recommendations based on goals of care discussions (Childers et al., 2017; Mott et al., 2021). Not having the proper communication skills can lead to barriers in medical care (Back et al., 2019). Experienced clinicians and residents often stated that they did not feel confident and lacked the communication training to have goals of care discussions with patients (Jain & Bernacki, 2020; Wang et al., 2019). Moreover, teaching communication skills to medical learners has shown to improve patient satisfaction with treatment (Germaine et al., 2021; Harrington et al., 2020; Wang et al., 2019). Accreditation institutions in medical education recognize the importance of preparing medical learners for varying communication situations (Eertwegha et al., 2013; Puchalski et al., 1999). Furthermore, along with scholars, medical

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[3] A version of this chapter was presented at the 11th Annual Association for Assessment of Learning in Higher Education Annual Conference 2021. Virtual.

accreditation agencies agree that gender and level of education are factors that can impact communication styles. (Eertwegha et al., 2013; Puchalski et al., 1999; VanPatten, 2016). Harrington et al. (2019) link the comfort and confidence (i.e., perceived effectiveness) in communication to the increase in clinical skills when providing care. Furthermore, one goal of the residency process is building a feeling of effectiveness in care that allows residents to act without supervision. According to ten Cate et al. (2021), this will enable residents to "feel increased responsibility to their teams and patients as a valued partner in a health care team" (page s98). Self-reflection, such as feeling effective in their tasks, will be essential in the ongoing learning required throughout a physician's career (Harrington et al., 2020; Schumacher & Turner, 2021; ten Cate et al., 2021). The purpose of this study is to examine medical learners' perceived effectiveness in the communication skills needed to conduct goals of care discussions after a communication training.

Literature Review

Goals of Care Communication

A type of communication leading to positive clinical outcomes for patients is known as goals of care (GOC) discussions. The concept of GOC describes a complex process surrounding the physician-patient interaction that involves "discussing prognosis, responding to patient emotion, exploring values and often making a recommendation for medical treatments that fit those values" (Childers et al., 2017, p. e844). Although there are various patient-centered interactions modalities, medical practitioners agree that communication is an essential part of reducing stress when patients are engaged in making shared healthcare decisions (Back et al., 2019; Boissy et al., 2016; Brem et al., 2021; Mohd Hanafiah et al., 2021; Schumacher & Turner, 2021). Residents are the primary individuals conducting GOC discussions internationally

because they provide the most direct patient care (Gorman et al., 2005; Rodenbach et al. 2020). In addition, residents' perception of effectiveness in having conversations with patients relies on prior communication training in using the patients' information to make healthcare treatment recommendations that align with the patients' values (Mott et al., 2021; Rodenbach et al. 2020; Schumacher & Turner, 2021).

Residents' and physicians' communication skills can be applied in care discussions and help to create a shared care plan of medical recommendations that do not conflict with patients' values (Germaine et al., 2021; Harrington et al., 2020; Jain & Bernacki, 2020; Mott et al., 2021). Healthcare recommendations based on patient values are more likely to lead to higher rates of patient compliance with treatment (Siropaides, 2018). However, GOC discussions conducted without the proper training on empathetic communication can become a liability and may have adverse outcomes like ". . . deprioritizing compassion, communication, and advocacy, GOC discussions devolved into administrative tasks that were more about medicolegal form completion than about evaluating the overarching clinical picture as intended" (Wang et al., 2019, p. 1237). In addition, without communication training, traits such as empathy become a barrier in having GOC discussions, and residents and physicians are left to feel uncomfortable making medical recommendations and responding to patients' emotions (Jain & Bernacki, 2020; Wang et al., 2019).

Goals of Care Discussion Training in Medical School

Effective communication includes goals of care discussions that have positive outcomes for patients and physicians (Sekar et al., 2021; Siropaides et al., 2020). Effective communication of GOC reduces anxiety and stress while helping with shared decision-making between the patient and physician (Dorough et al., 2021; Ma et al., 2021; Pollak et al., 2019). However, the

types of communication needed to implement GOC discussions are still up for debate within medical policies and practices (Aleksova et al., 2016; Dorough et al., 2021; Mott et al., 2021; Wittenberg et al., 2021).

Not having the proper training on GOC discussions can decrease empathy and patient-centered communication skills among medical learners and lead to long-term effects on a physician's professionalism and patient care (Wang et al., 2019). A feeling of effectiveness during GOC discussions helps physicians maintain focus and successfully align treatment with patients' values, which is essential in decreasing emotional destress (Aleksova et al., 2016; Childers et al., 2017; Mott et al., 2021; Pollak et al., 2019). In addition, learners' feeling of effectiveness positively impact patient outcomes and helps relieve the tension between clinical efficiency and patient-centered care (Wang et al., 2019).

Teaching communication skills to facilitate GOC discussions takes more than just observation of others' practice, but also requires ongoing feedback to the learner to increase quality outcomes (Pollak et al., 2011; Pollak et al., 2019; Sekar et al., 2021; Siropaides et al., 2020). In addition, physicians in multiple fields have noticed the lack of communication training in preparing medical learners for difficult conversations with patients and families (Chidume et al., 2020; Childers et al., 2017; Harrington et al., 2020; Ma et al., 2021; Rodenbach et al., 2020). Because residents are often involved in conducting GOC discussions, there is a need to examine how they assess their communication skills when interacting with patients.

Residents' Feelings of Effectiveness in Having Goals of Care Discussions

We have established that residents are usually responsible for having GOC discussions with patients and families. Still, residents have reported feeling unprepared, ineffective or uncomfortable conducting those conversations with patients and making recommendations based

on those discussions (Harrington et al., 2020; Rodenbach et al., 2020). Enabling residents and physicians to gain confidence in having effective GOC discussions will lead to a necessary "… shift in organizational culture, leadership recognition, and involvement, and support for provider readiness through education, and interdisciplinary and cross-disciplinary efforts" (Ma et al., 2021, p. 1547). Therefore, it is critical that residents receive training to become confident in taking a patient-centered approach and find an efficient way to lead those conversations throughout their medical training. The study will address two research questions:

1. Do residents' perceptions of GOC preparedness (i.e., GOC training prior to residency, practice of GOC discussions, alignment of medical recommendations and patient goals) differ by gender and year of residency?

2. Does the overall perceived effectiveness of having GOC discussions change after communication training? Does the change differ by gender and year of residency?

Method

We developed a survey to assess the residents' level of preparedness to have GOC discussions, as well as evaluate the perceived effectiveness of having GOC discussions after conducting communication training. The survey was administered during a communication training course developed for residents in their first, second, and third years of residency, and consists of pre- and post-training surveys (Appendix I and II)). The training was part of clinical skill initiatives at a medical university in the Southern United States, with the scope to introduce internal medicine residents to the use of communication skills related to conducting GOC discussions.

Communication Training Intervention

A multi-day training on how to conduct goals of care was provided by a palliative care physician that was certified in communication initiatives in healthcare. The training was conducted in a simulation center and used evidence-based practices that engaged over 100 residents on feedback, observation, and GOC communication skills. The residents were given scenarios to measure their response to patient emotions, assess and align their recommendations with patient values, and reframe the discussion to determine shared clinical outcomes (Childers et al., 2017; ten Cate et al., 2021; Wittenberg et al., 2021).

Research Sample

The research sample was narrowed down to participants who completed the entire pre- and post-training surveys, which consists of 114 internal medicine residents. In addition, the participants were asked to identify their gender and residency year. The sample consisted of 38 first year, 36 second year, and 40 third year residents. The gender composition was 54 females and 60 males, with no participants identifying as other.

Survey Instrument

The survey instrument consisted of 22 pre-training questions and 25 post-training questions focused on GOC discussions. The final survey used in this study was narrowed down to 20 pre- and post-training survey questions related to the resident's perception of GOC preparedness characteristics and the overall effectiveness of GOC training from which we selected several questions for analysis. Appendices I and II provide the pre- and post-training survey administered to the residents, with asterisks that indicate the specific questions analyzed in this study.

The first set of two pre-training and one post-training survey items focused on residents' perception of GOC preparedness (i.e., GOC training prior to residency, practice of GOC discussions, alignment of medical recommendations and patient goals) and used a 5-point Likert scale (Germaine et al., 2021; Harrington et al., 2020; Jain & Bernacki, 2020; Mott et al., 2021) from "Never/None', "Rarely", "Sometimes", "Often" to "Always". Specifically, the first survey question was about receiving training on conducting GOC discussions in medical school before residency. The second survey question was whether the residents conducted GOC discussions with patients. The third survey question asked about the confidence felt when making healthcare recommendations that align with patient goals. Each of these three questions were analyzed to determine differences by year in residency and gender regarding the resident's preparedness on having GOC discussions. These survey items are part of the pre-training and post-training communication training sessions that incorporate simulated patient encounters to teach how to conduct GOC discussions.

The next set of five survey questions are used to compute the overall perceived effectiveness of having GOC discussions before and after the communication training to determine the impact of training and whether differences exist by residency year and gender. The survey questions were to determine if residents believe they were effective when doing tasks related to GOC discussions. In agreement with the literature, the survey questions were designed to find whether residents felt effective in those conversations when completing specific tasks. For example, the residents would need to have the ability to relay medical information to a lay audience such as patients that have varying levels of medical knowledge (Childers et al., 2017; ten Cate et al., 2021; Wittenberg et al., 2021). Equally important, the resident can respond to the emotions of patients' families, including emotions such as sadness, frustration, anger, and hope

with empathy (Harrington et al., 2020; Ma et al., 2021; Rodenbach et al., 2020). Furthermore, the resident would need to feel confident in assessing patient values and goals while aligning healthcare recommendations with established patients' values (Chidume et al., 2020; Childers et al., 2017; Harrington et al., 2020; Ma et al., 2021; Rodenbach et al., 2020). All survey questions are related to scenarios and discussions conducted during the communication training which was expected to increase residents' perceptions of having effective GOC discussions. The survey items were measured on 5-point Likert scale, from "Strongly disagree", "Disagree", "Neutral", "Agree" to "Strongly agree". The overall perceived effectiveness derived as a mean value is a continuous variable ranging from 1 to 5.

Data Analysis

To analyze residents' perception of GOC preparedness, we conducted three two-way ANOVA tests to find the main effects of gender and year of residency, and the interaction effects. Second, we conducted two mixed ANOVA tests to explore the changes in residents' overall perception of GOC discussions effectiveness after the communication training (time as within-subjects factor), and the main effects for either gender or year in residency (between-subject factors), and their interaction with the training intervention described as time.

Results

This section presents results of the analyses to address the two research questions. Two-way ANOVA and mixed ANOVA analyses are employed.

Residents' Perception of Preparedness for Goals of Care Discussions

Residents' perceptions of preparedness are based on three survey questions asked pre-training. For each preparedness indicator we conducted separate two-way ANOVA analyses to assess if there are any differences by year in residency and gender in the mean scores. Table 4.1

shows the descriptive statistics of survey items by year of residency and gender for: GOC

training prior to residency, practice of GOC discussions, and alignment of medical

recommendations and patient goals. ANOVA tests results are then presented and discussed.

Table 4.1.

Residents' Perception of Preparedness for GOC Discussions by Year of Residency and Gender

(Means and SD)

	Residency Year 1		Residency Year 2		Residency Year 3	
Measure	Male	Female	Male	Female	Male	Female
	(N=18)	(N=20)	(N=25)	(N=11)	(N=17)	(N=23)
GOC Training Prior to Residency	2.72	3.00	2.72	3.36	3.06	2.65
	(.67)	(.86)	(.91)	(.67)	(.83)	(.94)
GOC Discussion Practice	3.78	3.15	3.76	4.00	4.18	4.09
	(.65)	(.88)	(.60)	(.45)	(.81)	(.42)
Recommendations Aligned to	3.83	3.85	3.60	3.91	4.06	3.57
Patient Goals	(.79)	(.75)	(.65)	(.70)	(.66)	(.59)

Goals of Care Training Prior to Residency. A two-way factorial analysis of variance

was conducted to compare the mean scores of the GOC training prior to residency measure by

gender and year of residency. The interaction effect between gender and residency year was

statistically significant, $F (2, 108) = 3.147$ $p = .047$. There was no significant main effect for year

of residency, $F (2, 108) = .774$ so no further post-hoc comparisons were needed. The main effect

for gender, $F (1, 108) = .790$ $p = .376$, did not reach statistical significance.

Goals of Care Discussion Practice. A two-way factorial analysis of variance was

conducted to compare the mean scores of GOC discussions practice measure by gender and year

of residency. The interaction effect between gender and residency year was statistically

significant, $F (2, 108) = 3.861$ $p = .024$. There was a statistically significant main effect for year

of residency, F (2, 108) = 10.114, $p = <.001$. Post-hoc comparison using the Tukey HSD test indicated that the mean score for the first-year residents ($M = 3.45$, $SD = .828$) was significantly different (and lower) from second-year residents ($M = 3.83$, SD = .561) and the third-year residents ($M = 4.13$, SD = .607). The main effect for gender, F (1, 108) = 1.561 $p = .214$, did not reach statistical significance.

Goals of Care Recommendations Alignment with Patient Goals. A two-way factorial analysis of variance was conducted to compare the mean scores of the GOC healthcare recommendations alignment measure by gender and year of residency. The interaction effect between gender and residency year was statistically significant, F (2, 108) = 3.115 p = .048. There was no significant main effect for year of residency, F (2, 108) = .870 so no further post-hoc comparisons were needed. The main effect for gender, F (1, 108) = .178 p = .674, did not reach statistical significance.

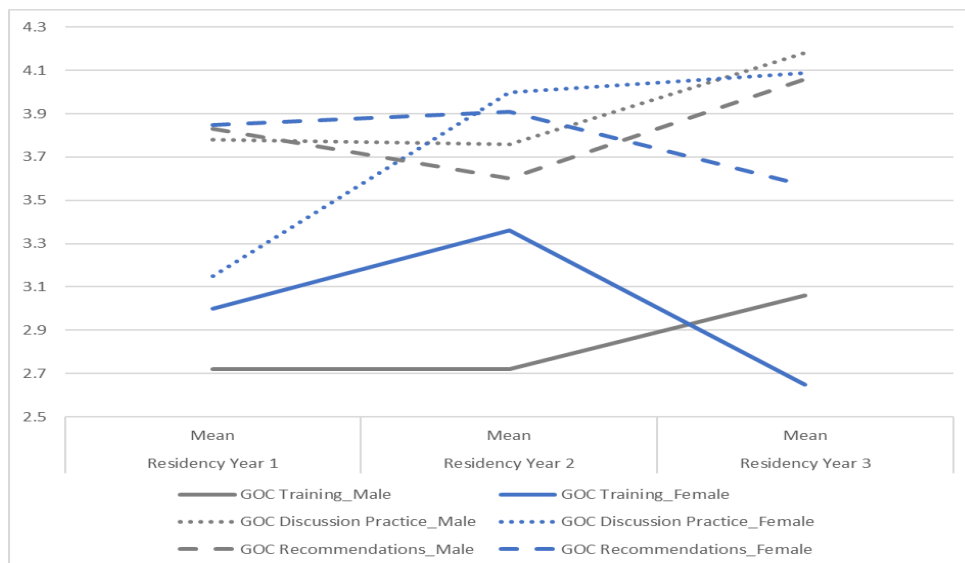Figure 4.1 shows a visual depiction of the mean scores for the three measures of GOC discussions preparedness as perceived by residents.

Figure 4.1. *Residents' Perception of GOC Preparedness Indicators by Year in Residency and Gender*

Overall Perceived Effectiveness of Conducting GOC Discussions

The second research question of the study focused on the perceived effectiveness of GOC discussions before and after the communication training. Two mixed ANOVA analyses explored the change in perceptions first by gender and second by year of residence.

Gender Effect. Mixed ANOVA analysis was conducted to assess the effects of gender and training intervention on participants' perceptions of the effectiveness of having GOC discussions. Table 4.2 shows the descriptive statistics comparing pre- and post-training mean scores by gender.

Table 4.2.

Overall Perceived Effectiveness of Conducting GOC Discussions by Gender (Means and SD)

Variable	Male (N=60)	Female (N=54)	All (N=114)
Effectiveness Pre-training	3.69 (.56)	3.53 (.47)	3.56 (.52)
Effectiveness Post-training	4.02 (.51)	3.99 (.57)	4.01 (.53)

There was no significant interaction between gender and time (training), $F(1, 112) = 0.018$, $p = .90$. There was a significant difference between pre- and post-training means, $F(1, 112) = 39.303$, $p = < .001$, with both gender groups increasing their perceptions of GOPC effectiveness after the communication training. The main effect for gender, $F(1, 112) = 0.740$. $p = .480$, did not reach statistical significance.

Year of Residency Effect. Mixed ANOVA analysis was conducted to assess the effects of year of residency and training intervention on participants' perceptions of the effectiveness of having GOC discussions. Table 4.3 shows the descriptive statistics comparing pre- and post-training mean scores by year of residency.

Table 4.3.

Overall Perceived Effectiveness of Conducting GOC Discussions by Residency Year (Means and SD)

Variable	Residency Year 1 (N=38)	Residency Year 2 (N=36)	Residency Year 3 (N=40)
Effectiveness Pre-training	3.47 (.52)	3.62 (.47)	3.60 (.56)
Effectiveness Post-training	4.02 (.51)	3.95 (.51)	4.05 (.45)

There was no significant interaction between time and year of residency, $F(1, 111) = 0.740$, $p = .480$. There was a significant difference between pre- and post-training means, $F(1, 112) = 39.303$, $p = < .001$, with all resident groups increasing their perceptions of GOC effectiveness after the training. The main effect for year, $F(1, 111) = 0.436$. $p = .648$, did not reach statistical significance.

Finally, as shown in Figure 4.2 (table is not included), the overall perceptions of GOC discussion effectiveness increase after the communication training for all gender-residency year groups. The increase is particularly noticeable for male residents in year 1 and year 3, and for female residents in year 2. The least change in perceptions after the training is shown by the male year 2 residents.

Figure 4.2.

Change in Overall Perceived Effectiveness of GOC Discussions by Year in Residency and

Gender
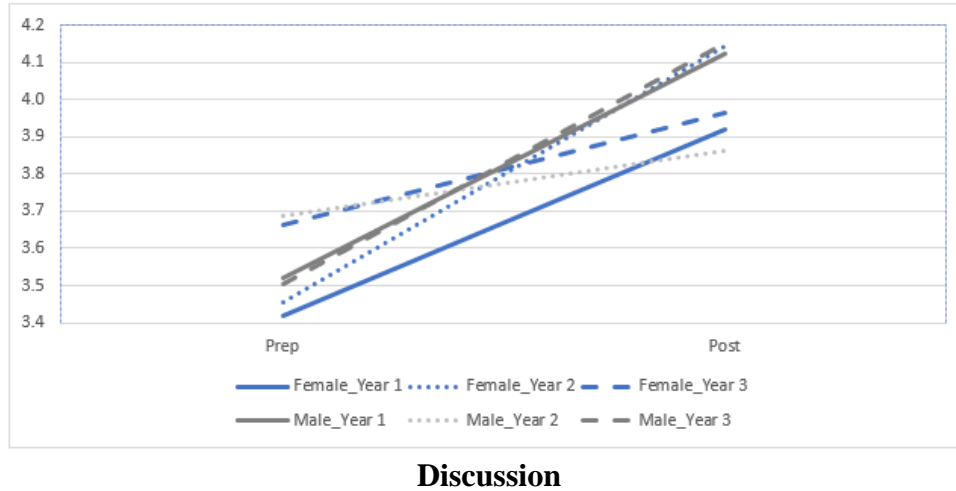
Discussion

This study found that residents felt more effective through communication training with respect to having healthcare conversations with patients and making healthcare recommendations based on GOC discussions with patients, regardless of gender and year of residency. Furthermore, this study explores how factors such as gender and year in residency affect a clinician's training. In addition, by examining the residents' perception of being prepared for GOC discussions, we found that the experience of females was similar to males in having GOC discussion practice, making GOC recommendations that aligned with patient goals and the amount of training received in medical school. However, more research needs to be done on the interaction effect between gender and residency year.

Research routinely shows an increase in confidence in GOC discussions after communication training (Harrington et al., 2020; Pollak et al. 2019; Rodenbach et al. 2020). The current study shows that after the communication training, the residents felt more effective in having GOC discussions regardless of year of residency and gender. This shows that residents should receive the same training, as it is beneficial to both gender groups and all residency

levels. Thus, internal medicine resident training can be consistent throughout, and the curriculum may not necessarily need to be changed for each year of training. This would allow for efficiency and standardization of training for GOC discussions in medical education. Communication is a critical element in GOC discussions and further research should address how to assist future physicians in being prepared to interact effectively with patients regarding their values.

Limitations

A limitation of the study is related to data being self-reported, which may result in biases. Additionally, the survey instrument was not based on a validated scale. Another limitation is that the study was conducted at a single institution, limiting transferability of findings. However, the current research design of can inform more extensive studies with access to multiple clerkships and health institutions.

Implications and Conclusion

Communication requirements are changing in medical education (Ma et al., 2021; Mohd Hanafiah et al., 2021; Wittenberg et al., 2021). Hence, this study suggests that preparing future physicians to have positive patient discussions is a skillset that should start early in medical education (Jordan & Foster, 2016; Vinson & Underman, 2020). The evaluation of communication skills is essential in understanding if the conversations between patients and physicians produce positive clinical outcomes according to the residents' points of view (Germaine et al., 2021). Furthermore, by evaluating resident's views of communication skills, an interprofessional alignment can be created to cross-train healthcare teams on a shared ideology of patient-centered communication (Jain & Bernacki, 2020; Ma et al., 2021). According to the findings in this study more research is needed to understand the past communication experiences of residents in medical school and during residency and the differences in experiences, training,

and practice based on gender. More curriculum development research is needed to explore the

most effective ways to teach all medical learners communication skills useful to conduct GOC

discussions.

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CHAPTER 5

DISCUSSION

Researcher's Standpoint

I began teaching communication at the undergraduate level in 2013 as an adjunct professor. As I moved into various roles within higher education, teaching has accompanied me in my journey. My expertise was conflict resolution, teamwork, business communication, and inter and intrapersonal communication. At UT Southwestern Medical Center, I was hired to teach communication. Teaching at a health institution was different than what I previously experienced in using communication; there was a desire for physicians and medical learners to help and serve patients, but also a disconnect with the skills needed to achieve these goals. I desired to bring in communication theories to assist in developing skills for interacting with patients and families. Then, as I started talking to friends and family outside of the medical field, there was a sense that physicians did not care about patients and just saw them as clients or even science projects. The desire to connect and be heard was on both sides when talking to individual groups, but neither group seemed to understand the other.

The medical practice involves patients, physicians, and policies and has a ripple effect within society. The theories and practices about communication are still being developed and debates existed among scholars regarding its utility in various fields (Finset, 2021; Germaine et al., 2021; Rajesh et al., 2021; Schumacher & Turner, 2021). However, none of the studies I found examined communication within policies, education, and practices of medicine. Thus, leading me to discover my research interest in understanding communication in the educational environment during my doctoral program.

Through my research at UT Arlington and UT Southwestern, I was given the skills to review the literature and examine policy that furthered my curiosity. I found that each medical specialty viewed the communication process differently and no one examined all of the policies and practices of communication in medical education (Back et al., 2019; LaNoue & Roter, 2018; Marathe & Bansal, 2018; Ranjan et al., 2015). Even more, policies involving the medical practices, standards, and competencies surrounding communication were being developed and changed during my coursework and while writing my dissertation (Howley & Engle, 2021; Katsufrakis & Chaudhry, 2021; Mohd Hanafiah et al., 2021; Schumacher & Turner, 2021). The COVID-19 pandemic created challenges in communication between physicians and patients (Lucey & Johnston, 2020; Wittenberg et al., 2021). Medical learners also had to make adjustments. The policies and educational standards are still in flux on how to ensure that necessary clinical communication skills are being taught within medical education (Brem et al., 2021; Finset, 2021). This is how I discovered the need and timeliness of examining communication within medicine. I felt that writing a dissertation about this process would provide another element for policymakers and physician educators to understand communication and further strive for providing more communication skills to medical learners. Additionally, a better understanding of the process helps me teach communication skills to medical learners from an evidence-based perspective. It is fascinating that the medical field has developed rapidly over time and has made up a subset of terms and ideologies surrounding the communication process that was different from other communication-driven fields (Abraham, 2010; Nugus, 2019; Spagnoletti et al., 2018; Victor, 1910). Communication is being transformed in the medical field from a suggestive measure to a requirement for successful interaction between patients and physicians (Dowson, 2019; Finset, 2021; Neumann et al., 2009). The transformation

of communication ideology was as intriguing to me as the goal of an effective communication model to improve care. The intrigue stems from the mentality that we may not all be physicians, but we will all be patients.

<div align="center">**Synthesis of Results**</div>

Conceptual Framework

The medicalization of communication conceptual framework presented in Chapter 1, propsoed to explore the use of communication in medicine from three perspectives. As stated in Chapter1, medicalization is an aspect of human life defined as a medical problem (Conrad, 1992, 2007; Parens, 2013). I started by hypothesizing that each of three domains (i.e., institutional, conceptual and interactional) offer different perspectives to examine the medicalization of communication. However, the research in this dissertation has led me to realize that an examination of medical communication is not possible in separation, and all three medicalization domains are often contributing simultaneously to the phenomenon. Furthermore, the policies in medical education are changing due to ongoing research in medical communication and changes in the medical practice. Changes in medical education policy are the result of policy feedback loops that evaluate the innovation, adaptation, and implementation within a phenomenon (Fowler, 2014). Therefore, I suggest an adaptation of the model proposed in Chapter 1 to include the connection between the three domains.

Thus, Figure 5.1 describes (dotted lines) that the communication has to be integrated throughout the field of medicine through each domain together or separately. Examining communication with the connection of the domains allows for a more complete understanding of the medicalization of communication. For example, this dissertation uses one of the empirical studies to examine the policies and educational standards surrounding communication. The

dissertation then goes on to explore the concepts that define the traits of physcians needed to interact with patients. The third study examines the communication skills necessary to attain clinical objectives in practicing medicine. Figure 5.1 suggests that the medicalization of communication is the result of the intertwining changes in policy, practice, and medical education.

Figure 5.1.

Medicalization of Communication Conceptual Framework Adaptation
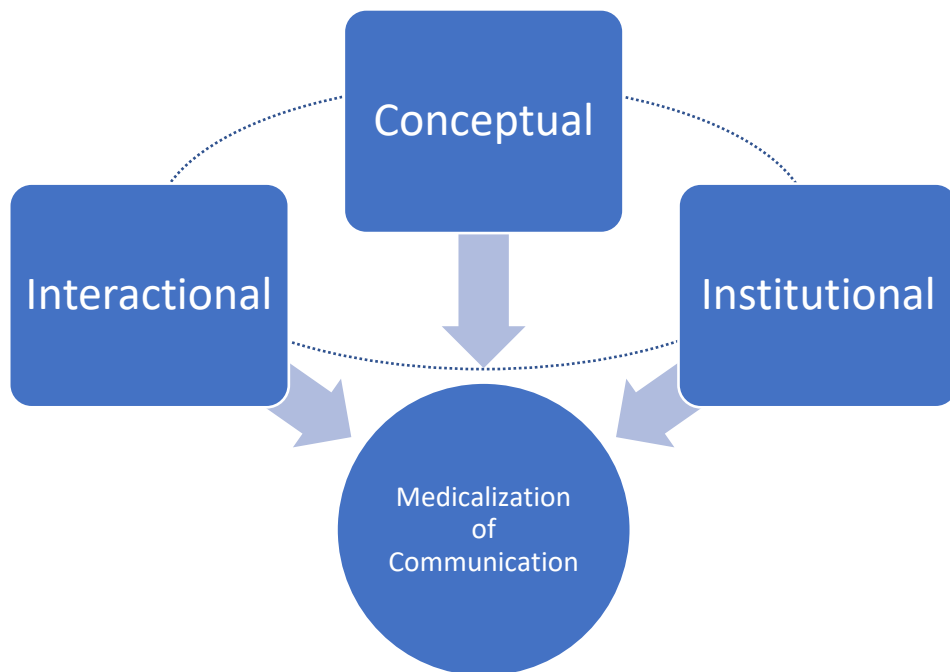
The medicalization of communication concept provides a complex yet timely examination of the shape of medical education in the interaction between patients and physicians. The concept frames the policies, communication types, and practice goals through three studies in this dissertation. Table 5.1 provides a summary of the studies included in this dissertation, including the related concepts investigated and the major findings of each study.

Table 5.1.

Summary of Chapters, Concepts, and Main Findings

Ch.	Study	Title	Domains	Major findings
2	1	Medicalization of Communication: An Examination of Communication Policies in Medicine	Institutional Conceptual Interactional	A cultural shift toward communication is happening in practice and policies in medicine, but no centralized communication standards exist across medical school, residency, or physician practice.
3	2	Association of Medical Student Characteristics and Empathy After a Communication Workshop	Conceptual Interactional Institutional	-The types of communication in medical education are unique and have created different modalities for providing positive clinical outcomes. -The intervention to improve communication vary based on gender and medical specialty. -Empathetic communication should be a multidiscipline approach evolving and creating curriculum changes to address the interaction between the patient and physician.
4	3	Medical Learners' Perceived Effectiveness in the Communication Skills Needed to Conduct Goals of Care Discussions	Interactional Institutional	-Effective communication in practice is essential in creating shared decisions with patients on medical care. -Goals of care discussions take training and practice should be addressed throughout medical training.

Research Objectives

In this section, I will discuss the research objectives presented in Chapter 1 by using as evidence the main findings of the three research studies on communication in medical education included in this dissertation, and in relation to the current research literature.

Research Objective 1. *To examine the institutional policies and standards regarding the use of communication in medical practice and education.*

Examining the institutional medicalization of communication is based on a critical discussion of policies and educational standards surrounding patient and physician interaction. Cockerham (2013) describes internalization of medicine as socialization in the training and credentialing that set the stage for future physicians. The creation of laws, policies, and competencies in education informs medical learners that are entering the field on what is expected of them as physicians. Thus, socialization is conducted through educational expectations and practices. Study 1 addresses communication as an exchange of shared interpretation between the physician and patient, but also between the research knowledge and the laws and requirements within the healthcare profession (Macchie, 2009; Suojanen et al., 2018; ten Cate et al., 2021; VanPatten, 2016).

Study 1 focused on the patient-physician relationship, showing that positive communication experiences lead to increased patient compliance and reduce barriers for physicians, patients, and healthcare teams (Kachalia et al., 2018; Mohd Hanafiah et al., 2021; Spagnoletti et al., 2018). Policies regarding communication exist in multiple areas of a physician's job, including ethical expectations, health information, and medical education. Communication skills needed for an effective interaction with patients and healthcare teams have continued to be one of the main topics of discussion within medical education and interest to

develop them has intensified over the past few years (Baker, 2021; Chidume et al., 2020; Clayton et al., 2013; Ferreira-Padilla et al., 2015; Finset, 2021; Morrison et al., 2020). Communication innovation is continuously regulated and taught throughout medical training and defined through policies to create improved healthcare. Study 1 provides a policy analysis to examine the interaction between physicians and patients withing the current context of normative policies. The study findings showed that communication is a critical part of the medical community. Examining the medical profession's policies demonstrates that the medicalization of communication has been an integral part of a physician's practice and education in the medical community and is socialized through laws and policies.

Every accreditation agency addresses medical communication, so the effort to develop communication training for medical learners extends into the medical institutions. Communication skills workshops in Studies 2 and 3 are a product of the laws and policies that surround the value of positive clinical interactions. Likewise, laws, bills, policies, and standards surrounding the interactions between patients and physicians translate into initiatives within the medical community. There is consensus that communication skills should be taught throughout the medical curriculum because of the institutional requirements shown in Study 1. The skills acquired and the confidence surrounding effective communication are determined by a shared lexicon, norms, and policies. This dissertation is looking at medicalization in a new light, but if a single element of medicalization was used, it would be institutional socialization of medical information through the policies, laws, standards, and bills put into place involving the patient and physician interaction (Batalden et al., 2001; Christopher et al., 2002; Friedmann & Leach, 1999; Gambert, 2007; Swing, 2007).

Research Objective 2. *To explore how types of communication are conceptualized when educating medical learners.*

Evaluating the conceptual medicalization of communication is represented in the lexicon created to describe a new type of empathy that examines the clinical interaction between patient and physician (Conrad, 2007; Hojat, 2016; Hojat et al., 2001; Maturo, 2012). Communication within education is not just about evaluating the messages from the sender to the receiver but operationalizing that method to assess patients' needs through clinical empathy (Stansfield et al., 2016; Suojanen et al., 2018; VanPatten, 2016). A medical learner's level of clinical empathy can positively affect the learner and their patients (Hojat et al., 2018; Hojat et al., 2002; Kaplan-Liss et al., 2018; Mohammadreza Hojat et al., 2002; Suojanen et al., 2018).

Study 2 examined the effects of a communication workshop on the level of empathy of medical students using the Jefferson Scale of Empathy, which was specifically created to evaluate the characteristics of empathy needed for medical professionals (Dorough et al., 2021). The widely used scale proposes a conceptualization of empathy for medical learners that is different from that of a layperson (Hojat, 2016; Hojat et al., 2018; Hojat et al., 2001). Clinical empathy consists of taking on the patient's perspective, having compassionate care, and walking in a patient's shoes (Hojat, 2016; Hojat et al., 2001). In this study, communication was used to increase clinical empathy that usually diminishes throughout medical training because doctors are expected to maintain clinical objectivity and detachment but causes physician burnout (LaNoue & Roter, 2018; *Palliative Care in Nephrology*, 2020; Sulzer et al., 2016). Therefore, the ways communication is taught has to be adapted to the type of empathy needed in the clinical environment.

Clinical empathy is a new concept that includes empathetic thoughts and actions while gaining medical information and maintaining clinical objectivity (Dorough et al., 2021; Riess, 2017). Clinical empathy is a new term that makes a case for the medicalization of communication through the conceptual domain. Clinical empathy is taught through communication to medical students to teach them how to build a relationship and trust between the patient and physician (Dorough et al., 2021). Responding to patients' emotions and expressing emotions empowers patients to be a part in shared decision-making in clinical care (Pollak et al., 2011; Riess, 2017; Zwingmann et al., 2017). Examining gender and specialty groups in Study 2 allows us to understand that the conceptualization of medicalization has a different impact on different medical learners. Studies 2 and 3 demonstrate how communication exists within the institutional, interactional, and conceptual domains. A shared finding within Studies 2 and 3 is that the curriculum should be developed to have both medical students and residents understand the types of communication needed to build empathy and create trust and shared decision-making in the interactions of patients and physicians. Although Study 3 focuses more on the interactional domain of medicalization, it also responds to the conceptual research objective through the development of resident training based on the Goals of Care (GOC) concepts in a care setting.

Research Objective 3. *To examine how medical education utilizes communication training to improve the interactional process between the patient and physician during the health care provision.*

Research objective 3 is matched to Study 3 that looks into the interaction between the patient and physician and the communication skills needed for residents in practice to be prepared and confident in healthcare conversations (LaNoue & Roter, 2018; Marathe & Bansal,

2018). Interactional medicalization principles are revealed in the communication training to improve GOC and clinical outcomes (Chidume et al., 2020; Dowson, 2019; Jain & Bernacki, 2020; Kachalia et al., 2018). Study 3 examined data from residents surveyed on their perception of preparedness in their interactions with patients, which was defined by the effectiveness of care, confidence in having GOC discussions with patients, confidence in making recommendations that align with patient values, and the perceived value of GOC training. Study 3 found that residents felt more effective having healthcare conversations with patients and making healthcare recommendations based on the communication training in which they have been exposed to scenarios allowing them to practice the skills.

Study 3 recognizes that the interactional process between the patient and physician is an integral part of defining medical problems and determining clinical care that aligns with patient values as has been demonstrated in previous research (Aleksova et al., 2016; Back et al., 2019; Boissy et al., 2016; Chidume et al., 2020). In addition, the interaction between patients and physicians relies on shared knowledge and an understanding between the individuals involved and the healthcare situation to provide clinical care. In short, the medicalization of communication assists in examining how communication is utilized to improve the interaction between patient and physician while conducting GOC discussions.

Summary

In summary, Research Objectives 1 and 2 examine the policies and characteristics of the communication between the patient and physician. Study 1 specifically examines the environment surrounding individuals entering the medical field and physicians currently practicing and shows the socialization that is a part of communication in medicine. The policies currently in place affect the field of medicine by establishing that guidelines are needed to teach

how medical learners should interact with patients. Without current policies that value the communication process, research in Study 2 may not be conducted, because is based on conceptual characteristics of clinical empathy needed in medical communication. The interactional domain examined in all three studies goes on to assist in defining how to practice medicine successfully and what communication skills learners must have that facilitate interaction and interpersonal communication with patients, including a manifestation of feelings, thoughts, and desires. The medicalization of communication between patient and physician encompasses all three domains established by this dissertation. This recognition is solidifying that communication in medicine is valued and evaluated based on the policies, standards, and practice that affect patients, physicians, and medical learners (Back et al., 2019; Boissy et al., 2016; Dorough et al., 2021; Finset, 2021).

The changes in the medicalization framework to connect all three domains is building a foundation for institutional socialization through policies and education. In addition, a conceptualization of the specific lexicon assists in training future physicians on communicating effectively to increase the quality of care through the interaction of the patient and physician (Conrad, 1992; Dorough et al., 2021; Harrington et al., 2020; Hojat et al., 2018; Hojat et al., 2002). Thus, utilizing the medicalization framework with all three studies makes a case that effective clinical interaction is created by providing information through a shared understanding from an ethical and empathetic stance. Therefore, the medicalization of communication is evident in the policies, education, and practices of all aspects of medicine.

Contributions to Research and Theory

Cockerham (2013) states that medicalization is the examination of both process and behavior within an organization (i.e., medical education) and in the practices of individuals.

Medicalization at times has been evaluated separately with the 3 domains presented in the conceptual framework adopted in this dissertation. Nevertheless, the core of my dissertation is about medical professionals and how "Physicians are trained to diagnose and treat alignments, conditions, and disorders to reduce patient's discomfort, vulnerability, disability, risk, pain, and suffering" (Cockerham, 2013, p. 205). Therefore, this dissertation makes the case that medicalization of communication is the crucial element that exists at the core of a physician's practice.

Contribution to Medicalization Theory

The medicalization concept has been used to discover illness, disorders, and significant changes in medicine that impact the medical community and the patients they serve (Cockerham, 2013; Conrad, 2007; Foucault, 1973). The primary role of medicalization is to examine the impact medicine has on society through concepts, institutions, and interactions (Conrad, 2007). The conceptual framework adopted in my dissertation surrounds the use of language in interacting with patients and stakeholders and creating rules and regulations to have a shared understanding. Based on the evidence provided by the research, I propose that a natural expansion of the theory lies within the interactions that combine all three domains. The medicalization framework allowed me to identify the problem medical learners face, i.e., medical students and residents lacking formal training in communication skills (Pieters et al., 2019).

The need for communication training goes beyond the interactions within individual medical specialties. For example, Back et al. (2019) state that although communication has increased clinical outcomes, up to 50% of physicians in some specialties were not provided evidence-based communication skills training. Upon closer examination of communication practices and policies in medical education, a framework that described the socialization and

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transformation of communication in medicine was appropriate. This dissertation found that communication training policies and standards in undergraduate medical education are different from graduate medical education, but all medical learners are still expected to have effective clinical communication skills (Dowson, 2019; Germaine et al., 2021; Suojanen et al., 2018). Although there are various frameworks involving patient-centered communication, all agree that communication is an essential part of medicine (Back et al., 2019; Brem et al., 2021; Broukhim et al., 2019; Spagnoletti et al., 2018). The medicalization of communication framework allows one not only to understand the importance of patient-doctor interactions, but also that communication goes beyond patient interaction, and involves policies that influence the interaction and medical learners' skills needed to make communication successful in a clinical setting. A concept such as clinical empathy also addresses the individual's interpersonal requirements to have successful interactions (Hojat et al., 2001; Salmon & Young, 2011; Sebok-Syer et al., 2021). Utilizing all three domains of medicalization also allows for expanding the framework to include other conceptual elements such as communication to help investigate clinical interventions in medicine (Kaczmarek, 2019; Maturo, 2012; VanPatten, 2016). In addition, expanding the framework allows more evaluations on nonmedical phenomena involving communication within medical teams, interprofessional teams, and different medical organizations' standards, policies.

Empirical Research and Data Collection Contribution

Research shows that communicating clearly and respecting patients' emotions, in turn, increases physicians' confidence in making recommendations that align with the goals of the patients (Boissy, et al., 2016). In addition, patient outcomes may improve when interacting with physicians who better communicate and respond to their emotions. (Tavakoly Sany et al., 2020).

Recognizing and responding appropriately to patients' emotions is crucial for improving patient care, yet medical learners feel that communication skills are not integrated enough into the curriculum to train them for actual clinical practice (Back et al., 2019; Baker, 2021; Pieters et al., 2019; Weber et al., 2016).

Two of the studies in this dissertation are based on the analysis of data that support the conceptual and interactional domains of medicalization. The need for clinical empathy stated in Study 2 specifically reminds how medical learners should understand things from a patient's perspective. Training for building communication skills needed for patient interactions is presented in Study 3. My studies found that the enhancement of physician and patient interaction requires communication skills. Study 3 explains the importance of GOC training to make healthcare recommendations based on patient values and that confidence in communication is important in interacting with patients. Not having the proper skills when engaging in medical practice leads to reluctance in having GOC discussions and decreases the likelihood of making healthcare recommendations based on patient values (Harrington et al., 2020; Jain & Bernacki, 2020; Kachalia et al., 2018; Kerr et al., 2020). My research contributes to the literature that show that becoming proficient in GOC discussions requires communication training that will build confidence in future physicians (Pollak et al., 2019). Furthermore, communication skills surrounding GOC discussions lead to better patient and physician interactions (Childers et al., 2017; Pollak et al., 2019; Siropaides et al., 2020; Stevens et al., 2020).

To further develop this area of research, an intradisciplinary approach would be most effective to allow scholars to examine the communication process through different paradigms and help provide educators, policymakers, and the medical community innovative ways to improve the interaction between patient and physician. I suggest building a bridge that allows

communication scholars and the medical field to develop research initiatives to assist with the creation of shared goals based on all three domains of medicalization.

Implications for Higher Education Policy and Practice

This dissertation used three studies to examine the topic of communication between medical learners and patient. I will discuss some implications for policy and practice revealed by the studies.

Communication Data and Policies

First, more studies are needed from the patient's perspective and other healthcare professionals to further understand communication in the medical field. All three studies created an argument about the negative aspects of poor communication which suggests more needs to be done in terms of collecting data to understand other perspectives about the use of communication in the medical profession.

This dissertation discusses the driving characteristics of medicalization, patients as consumers, and managed care. Medicalization of communication allows researchers to recognize that for patients to manage their care and make decisions as public health consumers, there has to be a shared understanding of medical decisions through effective communication (Clarke & Shim, 2011; Clayton et al., 2013; Cockerham, 2013; Conrad et al., 2010). Unfortunately, miscommunication can also increase health disparities (Humphrey et al., 2020; Stanford, 2020). There are also risks to the physician, including increased burnout and feeling unsure in the abilities to serve patients (Clayton et al., 2013; Wittenberg et al., 2021). The policies and standards are currently changing within medical education and there is an opportunity for communication to be better integrated within the medical curriculum (Baker, 2021; Fatima et al., 2021; Giemsa et al., 2020; Lucey & Johnston, 2020). Factors such as race, ethnicity, and socioeconomic status have an influence on communication style and education (Dorough et al.,

2021; Puchalski et al., 1999; VanPatten, 2016). Thus, more data is needed for a deeper examination of the experiences of medical learners from various backgrounds within each stage of medical education. Data collection initiatives should go beyond patient satisfaction and/or the self-reports of medical learners, to focus explicitly on communication elements in the interaction with physicians, not just the intended health outcomes.

This dissertation also shows a need for a curriculum-driven change in approaching communication practice within medicine. Although the problem can be seen as a strictly medical community problem, by examining this from an educational and communication perspective, medicalization shows the need for clear policies and laws (Conrad, 1992, 2007; Conrad et al., 2010; Parens, 2013). Furthermore, taking an interdisciplinary approach to evaluating medical education and sustaining effective communication in medicine requires the participation of a multidisciplinary community to assist in finding solutions to align the communication training and education to the current needs of the community it serves. This action cannot be taken in isolation, so there is need to examine the policies, educational standards, and concepts involved in the interaction between patients and physicians to help determine the best communication skills needed to train future doctors. Since research shows that physicians lack the time to research different paradigms in theoretical communication and practices (Bylund et al., 2012; Cameron, 2009), this dissertation proposes an interdisciplinary approach to examining how patient-centered communication training is rooted in evidence-based practices.

Communication Curriculum in Medical Education

This dissertation showed that a shared communication curriculum is necessary to facilitate effective communication between patients and physicians. Medical education has the potential to address the medical curriculum and includes interpersonal and intrapersonal

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communication tools to address cultural bias, humility, and health disparities (Bylund et al., 2012). In addition, patient-centered cultural communication skills assist with clinical outcomes, decreased burnout, and an increase in job satisfaction (Back et al., 2019; Bylund et al., 2012; Cameron, 2009; Chidume et al., 2020). Understanding the overall risk factors of poor communication and the positive impact of effective communication is important for reaching health equity (Back et al., 2019; Bylund et al., 2012; Cameron, 2009; Mohd Hanafiah et al., 2021). So communication curriculum should be designed to raise awareness among medical learners about social and cultural differences of patients.

Awareness of the research and practices that exist in communication theories has the potential to have a positive effect on patient and physician interaction and medical education as a whole and should be implemented in the medical curriculum (Henry et al., 2013; Kirschbaum & Fortner, 2012). This dissertation's examination of the medicalization of communication allows for a broader examination of communication beyond individual specialties and examines the policies, practices, and education surrounding the interaction of patients and physicians through different communication theories. In addition, the medicalization of communication allows for a reason to look at treatments and protocols to create a standardization of practice to create consistency, equality, and equity in communication within policies, practice, education of medical learners, and the medical community. Thus, communication skills training should be implemented in the medical school curriculum, ensuring that medical learners are able to contextualize multiple communication situations while providing care (Eertwegha et al., 2013; Finset, 2021; Salmon & Young, 2011; Wittenberg et al., 2021).

Significance of the Study

Scholars

Medical students and residents are required to meet communication competencies, but the focus on communication in medicine does not require a formal assessment to evaluate whether communication transfers to clinical training (Ecker et al., 2018; Eertwegha et al., 2013; Howley & Engle, 2021). This dissertation showed that the link to communication skills training should be related to outcomes, ensuring that students can contextualize multiple communication situations (Fatima et al., 2021; Howley & Engle, 2021; Salmon & Young, 2011). To monitor communication, a shared definition of effective communication types for individuals in all stages of medicine could standardize training. Therefore, this dissertation offers an example of such endeavor that can be further addressed by more scholars.

The studies used in this dissertation show the importance of evidence-based practices to help physicians improve communication skills, to reduce harm, and increase confidence in interactions with patients (Kaplan-Liss et al., 2018; Kwong, 2017; Suojanen et al., 2018). Having an interdisciplinary approach can allow for more scholarly involvement in medicine that will help identify which communication theories are important and useful in understanding how clinical interaction affects a person's well-being and livelihood.

Practitioners and Educators

In the last five years, medical school and residency governing agencies have conversed about the need for introducing communication competencies in the curriculum as recommended by communication research (Howley & Engle, 2021; Kachalia et al., 2018; Katsufrakis & Chaudhry, 2021; Lucey & Johnston, 2020; Macchie, 2009; Morrison et al., 2020). This dissertation is timely because it provides an examination of the medicalization of communication, showing that communication is intimately threaded throughout physicians'

policies, practices, and educational socialization. Thus, calling for a need for communication scholars to work with physician educators to examine communication theories that best serve the medical community's needs. I argue that developing communication training should be the combined result of theory, policy and practice.

Policy Makers

The policy analysis study in this dissertation is based on policies changing quickly after the COVID-19 pandemic. For example, the medical community is currently reviewing and adapting how they educate medical learners and practice medicine (Kachalia et al., 2018; Katsufrakis & Chaudhry, 2021; Lucey & Johnston, 2020; Morrison et al., 2020). As policy involving communication changes, the physician educators are expected to teach a concept that was not a part of their curriculum and their approach could vary depending on specialty expectations and research findings (Kwong, 2017; Suojanen et al., 2018; Wittenberg et al., 2021). Providing customization of communication training without a baseline of basic skills could be difficult for students going into residency. However, if more learners examined communication practices and were exposed to communication theories early in the medical curriculum, they would have better tools when the time comes for patient interaction. The conversation that exists beyond the clinical environment has been established in this dissertation. Moreover, it is also important to understand the medical policies and the effects of how effective communication is practiced in medicine. The medicalization of communication shows that the communication process is complex and involves more than just the patient and physician interaction, but also the institutions that determine which individual skills are needed in the medical community.

Final thoughts

Physician- patient interaction does not happen without communication. Moving from policy to practice, further development of standards could lead to a concise communication approach to the medical curriculum throughout medical schools and with reinforcement during medical residency. This would require the accreditation agency to establish rubrics, milestones, and benchmarks relevant to be implemented at each learning level in the medical education curriculum. Thus, practitioners and scholars need to examine the medical education system that is central to healthcare and has impact on our lives. Medical educators' beliefs on the use of communication are crucial to physician's interaction with patients and diverse communities. The viewpoints of the structure of medical education are essential to all individuals who fall within it. The profession itself is bound by scientific information and by the interaction with the population it serves. With an interdisciplinary approach, lessons that have already been taught could be utilized to find the elements that already exist in fields such as medical education, sociology, and communication.

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Appendix A

IRB

September 10, 2020

Ramona Dorough
ELPS Doctoral Student
The University of Texas at Arlington

IRB Submission Inquiry & Project Determination of Non-HSR

Dear Ramona,

Thank you for contacting the UT Arlington Office of Research Administration; Regulatory Services regarding your dissertation using data from medical education associations.

Upon reviewing the information that you provided, it appears your dissertation data would not meet the definition of, "research with human subjects" as defined by the Office for Human Research Protections (OHRP) and would therefore not be subject to review or approval by the Institutional Review Board (IRB) at UT Arlington. Per the federal regulations at 45 CFR 46:

- *Research* is defined as, "a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge."
- A *human subject* in research is defined as, "a living individual about whom an investigator conducting research: obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens."

From the description of data provided, it appears that it does not meet the definition of human subject research, as the data will not be identifiable. The PI/research team will not have access to identifiers. 45 CFR 46.102 (e)(1) Human subject means a living individual about whom an investigator (whether professional or student) conducting research:

(ii) Obtains, uses, studies, analyzes, or generates *identifiable* private information or identifiable biospecimens.

Therefore, this project is not subject to review or approval from the UTA IRB, and you do not need to submit a protocol to our office at this time.

Please note that although IRB review is not required for this study, there may be other institutional requirements or agreements such as Data Use Agreements that pertain to this project. Please contact Dan Vincenzo, UT Arlington's Agreements Manager, at vincenzo@uta.edu for assistance in processing study-related legal agreements. In addition, it is your responsibility to abide by the UT Arlington Standards of Conduct and the ethical standards within your field for all projects and activities, even when IRB review is not required.

REGULATORY SERVICES SERVICES

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Appendix B

Pre-Training Survey

Appendix B includes the pre-session survey used in the communication skills training.

The information used in the research presented in this dissertation concerns year of residency and

gender, as well as specific survey items identified with * (#1, #8, and 18-22).

RESIDENT Goals of Care Training PRE-Session Survey
Tell us a little about yourself (don't worry, the survey is anonymous):

Year?   R1   R2   R3   Gender?   F   M   N/A

Future Career Plans (i.e., subspecialty):

Have participated in the Monday Recharge Goal of Care
Communication Course in **2017** _____ **2018** _____ (mark if yes)

Tell us about your patient communication training and experience (circle best response)**:**

	Never/None	Rarely	Sometimes	Often	Always/
1. How much instruction on discussing goals of care did you receive during medical school?*	1	2	3	4	5
2. How much instruction on discussing goals of care have you received during residency?	1	2	3	4	5
3. How often do you lead goals of care discussions?	1	2	3	4	5
4. How often does a faculty member directly observe you during goals of care discussions?	1	2	3	4	5
5. How often do you receive direct feedback about your goals of care discussions?	1	2	3	4	5
6. How often do you directly observe your intern or student during goals of care discussions?	1	2	3	4	5
7. How often do you give feedback to your intern or student after observing goals of care discussions?	1	2	3	4	5

Help us understand your current GOC (Goals of care) practice/education (circle best response)**:**

	Never	Rarely	Neutral	Often	Always

	Not at all	Not very	Somewhat	Fairly	Extremely
8. I have GOC discussions with critically ill patients.*	1	2	3	4	5
9. I avoid having GOC discussions.	1	2	3	4	5
10. I have GOC discussion early (first half) in a patient's hospital course.	1	2	3	4	5
11. I ask for feedback and guidance on GOC discussions from peers or faculty	1	2	3	4	5
12. I observe other trainees having GOC discussions	1	2	3	4	5

PLEASE TURN TO BACK TO COMPLETE SURVEY →→→

Tell us about your current level of confidence and effectivity in holding Goals of Care discussions (circle best response)**:**

I feel confident in my ability to:	Not at all	Not very	Somewhat	Fairly	Extremely
13. ...Reframe medical information/changes succinctly for a patient/family.	1	2	3	4	5
14. ...Respond to patient/family emotions (i.e., sadness, frustration, anger, hope).	1	2	3	4	5
15. …Assess patient values and goals	1	2	3	4	5
16. …Align with the patient's values.	1	2	3	4	5
17. …Make medical recommendations that align with the patient's values.	1	2	3	4	5

I feel that I am effective when:*	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
18. ...Reframing medical information/changes succinctly for a patient/family.*	1	2	3	4	5
19. ...Responding to patient/family emotions (i.e., sadness, frustration, anger, hope).*	1	2	3	4	5
20. …Assessing patient values and goals*	1	2	3	4	5
21. …Aligning with the patient's values.*	1	2	3	4	5
22. …Making medical recommendations that align with the patient's values.*	1	2	3	4	5

10. Anything else you want us to know? (Please write it here.)

Thank you for your input! Remember, <u>the survey is anonymous</u>.

Appendix C

Post Traning Survey

Appendix C includes the post-session survey used in the communication skills training. The information used in the research presented in this dissertation concerns specific survey items identified with * (# 6-10). Question number 10 (**) was analyzed individually and as a part of a group of questions to residents' perception of their effectiveness.

RESIDENT Goals of Care Training POST-Session Survey

Tell Us A Little About Yourself (remember, the survey is anonymous):
Year?   R1   R2   R3   Gender?   F   M
      N/A
Future Career Plans (i.e., subspecialty):
Have participated in the Monday Recharge Goal of Care
Communication Course in **2017** _____ **2018** _____ (mark if yes)

After today's session, to what extent do you agree with the following? (circle best response)**:**

I feel more confident in my ability to:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
1. ...Reframe medical information/changes succinctly for a patient/family.	1	2	3	4	5
2. ...Respond to patient/family emotions (i.e., sadness, frustration, anger, hope).	1	2	3	4	5
3. …Assess patient values and goals	1	2	3	4	5
4. …Align with the patient's values.	1	2	3	4	5
5. …Make medical recommendations that align with the patient's values.	1	2	3	4	5

I feel that I am more effective when:*	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
6. ...Reframing medical information/changes succinctly for a patient/family.*	1	2	3	4	5
7. ...Responding to patient/family emotions (i.e., sadness, frustration, anger, hope).*	1	2	3	4	5
8. …Assessing patient values and goals*	1	2	3	4	5
9. …Aligning with the patient's values.*	1	2	3	4	5
10. …Making medical recommendations that align with the patient's values. **	1	2	3	4	5

After this session, please answer the following: (circle best response)**:**

	Never	Rarely	Neutral	Often	Always
11. I will use skills I learned from the simulated patient encounter in my own clinical practice	1	2	3	4	5
12. I will have GOC discussions with critically ill patients.	1	2	3	4	5
13. I will avoid having GOC discussions	1	2	3	4	5
14. I will have GOC discussions early (first half) in a patient's hospital course.	1	2	3	4	5
15. I will ask for feedback and guidance on GOC discussions from peers or faculty	1	2	3	4	5
16. I will observe other trainees having GOC discussions	1	2	3	4	5

17. What went well with the simulated patient encounter? (Please write it here.)

18. What could be improved with simulated patient encounter? (Please write it here.)

19. What specific skills will you incorporate into your next goals of care discussion as a result of today's session? (Please write it here.)

After the session, to what extent do you agree with the following? (circle best response)**:**

To what extent do you agree with the following?	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
20. This session helped me improve my patient communication skills	1	2	3	4	5
21. I would recommend this teaching session to other trainees	1	2	3	4	5
22. I would like more communication teaching sessions that incorporate simulated patient encounters.	1	2	3	4	5

23. What specific feedback do you have for your small group facilitator? (Please write it here.)

24. Any specific small-group issues that we should know about for next time?

25. Any other thoughts, comments, suggestions for improvement? (Please write it here.)

Thank you for your input! Remember, <u>the survey is anonymous</u>.

Biographical Information

Ramona Dorough is a native Texan, born and raised in Royse City, TX. She graduated with an associate degree in general studies from Collin College and a bachelor's degree in communication studies and sociology from Texas A&M University-Commerce, then went on to get a master's degree in communication studies from the University of Texas at Tyler. She currently serves as an Assistant Professor in the Department of Health Care Education as well as an Accreditation and Assessment Specialist in the Office of Institutional Planning and Assessment at The University of Texas Southwestern Medical Center. She lives in Dallas, Texas with her husband, Grant Moore, and dog, Teddy.