Teaching and Assessing Communication Skills in Medical Undergraduate Training

[#]JYOTI NATH MODI, [*]ANSHU, JUGESH CHHATWAL, [$]PIYUSH GUPTA AND TEJINDER SINGH

From Departments of Pediatrics, Christian Medical College, Ludhiana, Punjab; [#]Obstetrics & Gynecology, People's College of Medical Sciences and Research Centre, Bhopal; [*]Pathology, Mahatma Gandhi Institute of Medical Sciences, Sevagram; and [$]Pediatrics, University College of Medical Sciences, New Delhi; India.

Correspondence to: Dr Tejinder Singh, Program Director, CMCL-FAIMER Regional Institute, Christian Medical College, Ludhiana 141 008, India. cmcl.faimer@gmail.com

Good communication skills are essential for an optimal doctor-patient relationship, and also contribute to improved health outcomes. Although the need for training in communication skills is stated as a requirement in the 1997 Graduate Medical Education Regulations of the Medical Council of India, formal training in these skills has been fragmentary and non-uniform in most Indian curricula. The "Vision 2015" document of the Medical Council of India reaffirms the need to include training in communication skills in the MBBS curriculum. Training in communication skills needs approaches which are different from that of teaching other clinical subjects. It is also a challenge to ensure that students not only imbibe the nuances of communication and interpersonal skills, but adhere to them throughout their careers. This article addresses the possible ways of standardizing teaching and assessment of communication skills and integrating them into the existing curriculum.

Keywords: *Communication, Interpersonal skills, Non-verbal communication, Medical education.*

Good communication skills are an essential component of physician-training. Effective communication between the doctor and the patient leads to better compliance, better health outcomes, decreased litigation, and higher satisfaction both for doctors and patients [1-4]. Some of the common barriers to good communication include use of medical jargon, inability to communicate in a simple language, arrogance, lack of enough time dedicated to the doctor-patient encounter, and frequent interruptions while the patient is narrating his problems [5-7]. Patients expect doctors to be supportive, non-judgmental, empathetic, and open and honest about details of their illness, choice of treatment, side effects of medication and expected relief in symptoms [8]. Doctors who listen actively, encourage their patients to ask clarifying questions, check for understanding, and value the privacy and comfort of their patients are appreciated [6]. In addition, the non-verbal aspects of communication such as body language, eye contact, facial expression, touch, gestures, and interpersonal distance are of extreme importance in building rapport between the doctor and the patient [7,9]. Besides clinical interactions with patients, doctors also have to communicate in writing for clinical documentation and referrals — all of which have medico-legal implications. Effective communication goes a long way in building a relationship of trust between doctors and patients.

NEED FOR TRAINING IN COMMUNICATION AND INTERPERSONAL SKILLS

Although medical trainees may imbibe some basic communication skills consciously or sub-consciously during their clerkship by observing their peers and senior colleagues, these are far from adequate to exhibit good communication skills in their professional careers [10]. Sadly, not all senior physicians are good role models, nor do they all demonstrate exemplary communication skills in their work each time. During interpersonal interactions in clinical settings, teachers display both positive and negative role model behaviors. Though not explicitly taught, these unspoken messages form part of the 'hidden curriculum', which influences students' development as physicians [11-12]. Further, communication skills need to be reinforced and practiced frequently throughout the course to be applied by professionals in their future careers [2,13]. Medical students themselves, and several professional bodies, have acknowledged the need to incorporate communication skills training within the formal curriculum [14-16]. The real challenge is to seamlessly integrate communication skills training with clinical training. We herein suggest ways to include training and assessment of communication and interpersonal skills for Indian medical graduates within the existing curriculum.

MODELS OF COMMUNICATION IN CLINICAL CONSULTATION

With improved understanding and changing times, models of communication during clinical consultations have evolved from simplistic to more complex ones. Some of these models include the Bayer Institute for Health Care Communication E4 Model, the Three Function Model/ Brown Interview Checklist, the Calgary-Cambridge Observation Guide, the Patient-centered clinical method and the SEGUE Framework for teaching and assessing communication skills [17-21]. Some of the salient features of these models are outlined in ***Table* I**. Each model outlines a framework of clinical consultation that includes clinical data gathering, rapport building and counseling about treatment. These serve as guides for trainees and trainers and also provide a standardized way of assessing (and giving feedback) for communication during a clinical consultation. Most models enlist the key steps in progression of a clinical encounter with component activities that are observable and measurable.

Since several models were in use, a consensus model delineating the essential steps in clinical consultation was developed by a group of representatives of the five models listed above, that were in contemporary use. This was called the Kalamazoo consensus statement [22] (***Table* I**).

While trainees might begin learning the process of clinical consultation by following the steps of one or more models, eventually every physician must develop his/her own approach that encompasses all the essential elements. These should appear as their spontaneous professional behavior, rather than mechanical adherence to a protocol.

COMMUNICATION SKILLS TRAINING SCENARIO IN INDIA

The acquisition of communication and interpersonal skills is recognized and documented as a core competency for physician training in many countries [16,23-24]. In India, while this is included as a requirement in the 1997 Graduate Medical Education (GME) regulations of the Medical Council of India (MCI), not enough concerted efforts have been made to teach or assess them in most medical schools [25]. In the absence of proper training, Indian medical students often have less than adequate communication skills [26] and the demand for formal training in this area has often been echoed [27-30].

The Vision 2015 document of the MCI reaffirms the need to schedule dedicated time for training in communication skills for Indian medical graduates [31]. They are expected to communicate appropriately with patients, families, colleagues and community, and behave as leaders and members of the health care team and system. The document proposes a two-month Foundation Course at the beginning of phase 1 where communication skills training is one of the many objectives.

The utility of this concentrated one-time training for communication skills can be challenged on two counts. Firstly, communication skills are best learnt when taught as part of a longitudinal teaching plan rather than a single-occasion training [1,2,32]. There is evidence in literature that the communication skills of medical graduates actually decline over four years of medical school when not reinforced periodically [2]. A longitudinal program of communications skills training spread over the entire MBBS course is therefore desirable.

Recently, in a positive move, the MCI has introduced a module for Attitude and Communication (AT-COM) skills training in a phased manner [33].

TRAINING IN COMMUNICATION SKILLS

A good communication skills training program should be multi-session and multi-disciplinary, use multiple methods, and have opportunities for demonstration, discussion, reflection, practice and feedback [34,35]. A longitudinal teaching plan which defines the objectives based on contextual requirements for that phase of training and introduces complexities of doctor-patient communication sequentially through the course is recommended [1,2].

We have tried to outline the different competencies which can be delivered to medical graduates in the three phases of the MBBS curriculum in ***Table* II**. Settings in the existing curriculum where all departments can together teach and assess these competencies have also been identified (***Table* II**).

For communication skills training, instructional methods such as lectures and seminars are less effective than experiential methods supplemented with feedback [36,37]. Experiential methods (like role plays, or interaction with simulated and real patients) are preferred by students as they help in reinforcing strengths and identifying weaknesses in the component skills of communication [8,38]. A brief description of some of these methods follows:

Video recordings: Good quality video recordings of doctor-patient interactions (real or simulated) can be used by facilitators to stimulate discussions and give feedback in specific contexts [1,39]. While creating videos, it is important to take informed consent from the patients who are filmed, and maintain confidentiality of the doctor-patient exchange. These recordings must be non-obtrusive to the actual doctor-patient interaction. Learners can also consent to record themselves while conducting patient interviews, and view themselves on camera later. When

TABLE I MODELS OF COMMUNICATION DURING CLINICAL CONSULTATIONS

Model, year	*Essential elements of doctor-patient interactions and the constituent actions/behavior **
BIHC Communication E4 Model, 1994 [17]	1. Engage 2. Empathize 3. Educate 4. Enlist
Three Function Model, 2000 [18]	1. Data gathering: Gathering data to understand patient's problems • Attentive listening, open-ended and closed-ended questions, simple language, facilitating, checking, clarifying, summarizing, etc. 2. Emotions: Developing rapport and responding to patient's emotions • Reflection, legitimation, understanding, convey empathy, support, partnership, respect 3. Education and motivation: patient education and motivation (behavior) • Elicit existing views, educate, negotiate, motivate, reinforce
Calgary-Cambridge Observation Guide, 1996 [19]	1. Initiating the session • Establishing initial rapport: greet, introduce, demonstrate respect • Identifying the reason(s) for consultation: listen identify problem list 2. Gathering information • Exploration of the patient's problems to discover the biomedical perspective (disease), essential background history, patient's perspective (the illness): encourage, listen attentively, facilitate patient's responses verbally and non-verbally, clarify, encourage patient to express feelings, ask open-ended and closed-ended questions, pick up verbal and non-verbal cues to understand patient's perspective 3. Physical Examination 4. Explanation and Planning • Providing the correct amount and type of information • Aiding accurate recall and understanding • Incorporating the patient's perspective: achieving shared understanding • Planning: shared decision making 5. Closing the session • Summary, contract, safety netting, final check
Patient-centered clinical method, 1995 [20]	1. Assessment of patient's holistic experience of their health care. 2. Integration of the concepts of disease and illness with an understanding of the whole person 3. Finding common ground with the patient 4. Maintaining a focus on health promotion and disease prevention 5. Emphasizing the significance of patient-healthcare-practitioner relationship 6. Being realistic
SEGUE Framework, 2001 [21]	1. Set the stage; 2. Elicit information; 3. Give information; 4. Understand the patient's perspective; 5. End the encounter; 6. If suggesting a new or modified treatment/ prevention plan
Kalamazoo Consensus statement, 2001 [22]	1. Open the discussion • Allow the patient to complete his/her opening statement; • Elicit patient's full set of concerns; • Establish/maintain a personal connection 2. Gather information • Use open-ended and closed-ended questions appropriately; • Structure, clarify, summarize information; • Listen actively using verbal and non-verbal techniques 3. Understand patient's perspective • Explore contextual factors: family, culture, gender, etc.; • Explore beliefs; • Acknowledge and respond to patient's ideas, feelings, values 4. Share information: • Use language that patient can understand; • Check for understanding; • Encourage questions 5. Reach agreement on problems and plans • Encourage patient to participate in decisions • Check patient's willingness and ability to follow the plan • Identify and enlist resources and supports 6. Provide closure • Ask whether the patient has any other issues or concerns • Summarize and affirm agreement with plan of action

** Each of the models enlists several micro skills under each essential element or behavior. Only some of these have been given here. These micro skills make the process observable and measurable, and facilitate specific feedback. BIHC: Bayer Institute for Health Care.*

TABLE II KEY COMMUNICATION COMPETENCIES THAT CAN BE TAUGHT AND ASSESSED IN DIFFERENT PHASES OF THE MBBS CURRICULUM

Time in MBBS course	*Key competencies to be delivered*	*Possible settings in existing curriculum*	*Possible training methods*	*Possible assessment methods*
Phase 1				
(I-III semester; Preclinical and early paraclinical)	- Building rapport with people - Basic interviewing and data gathering skills: active listening, display respect, being mindful; awareness of barriers to communication; non-verbal communication and body language; awareness of cultural contexts of patients; demonstrates empathy - Demonstrates ability to work in a team - Demonstrates respect for patients, peers, seniors and other health care professionals	- Community exposure visits - OPD settings - Communication skills laboratory	- Writing reflections - Role plays - Group discussions - Group projects	- Grading and feedback on reflections
Phase 2				
(IV-VII Semester; Paraclinical and early clinical)	- Awareness of professional roles and responsibilities of a physician - History taking and clinical examination skills - Demonstrates respect for patient privacy and confidentiality in patient care - Awareness of work ethics and medico legal aspects - Taking informed consent - Proper prescription writing - Addressing patient queries about procedures; explaining diagnostic and therapeutic options to patients or family members; checking understanding when giving instructions - Allowing patients to participate in decision making; understanding patient perspectives and contexts; reaching a shared agreement on treatment options	- Clinical postings: OPD and wards - Community visits - Lectures - Communication skills laboratory	- Role plays - Videos - Sessions on prescription writing - Observing and shadowing clinicians - Practice sessions using real or simulated patients - Writing reflections	- OSCE - Feedback from trained simulated patients - Mini-CEX - Grading and feedback on reflections
Phase 3				
(VIII-IX Semester; Clinical years + Internship)	- Counseling skills: explaining diagnosis and prognosis - Providing health education to bring about behavioral change - Breaking bad news - Communicating news of terminal illness - Ability to maintain proper documentation in health care	- Clinical postings: OPD and wards - Lectures - Community visits - Communication skills aboratory	- Role plays - Videos - Observing and shadowing clinicians - Practice sessions with real or simulated patients - Writing reflections	- OSCE - Feedback from trained simulated patients - Mini-CEX- - Directly observed procedural skills (DOPS) - Grading and feedback on reflections

these recordings are viewed by trainees on their own, or discussed with a facilitator, they help in clarifying the impact of their verbal and non-verbal behaviors.

Simulated patients: Trained simulated patient are useful for learning skills, and can be used multiple times for the same scenario or different scenarios [40]. Simulated

patients can also be trained to give feedback in some situations [41]. The appropriate selection of case-scenarios to match the suitable simulated patient needs careful attention. Their training has to be ongoing, they need to be adequately paid and given enough time to learn. The simulated patient program needs significant administrative inputs to maintain records, develop case scenarios and run the sessions.

Role-Plays: Role-plays offer significant practical advantages over video recording and simulated patients. Here, one of the students enacts a particular role in a given script and can also improvise on personal responses to suit the scenario [42,43]. The facilitator and peers give feedback after the session. Cases can be repeated with different sets of students for other sessions and role-plays do not require any significant training or expense. Role-plays have the potential to provide opportunity for rehearsal, improvisation and even marking difficult, problem cases. One of the main drawbacks of role-play methodology can be the ability of acting out, especially since students are not actors. It may not be easy for them to come out of the 'doctor' character to be a 'patient'.

TRAINING IN NON-VERBAL COMMUNICATION

Training in non-verbal communication goes hand-in-hand with training in verbal communication. Clinicians not only need to convey the appropriate non-verbal cues through their body language, but must also be sensitive enough to pick up patients' non-verbal behavior. Many of these behavior patterns are context-dependent and vary with culture and region. Role plays and 'theatre' have emerged as methods of getting the students to reflect and learn about the importance of voice, tone or body language [44]. Forum theatre is a new experiential method which can overcome some of the drawbacks of role-play [45]. It has been widely used in clinical settings, especially in nursing education [46,47].

Students too have to be aware that besides what they learn during training sessions, they need to observe teachers performing in clinical settings. When they observe gaps between what they see and what they were taught, they must be encouraged to reflect, so that they benefit from both positive and negative experiences. Use of narratives, stories and biographies have been recommended to teach students for this purpose [48,49].

While a very wide range of behavioral and language characteristics contribute to good doctor-patient interactions, most training programs in communication skills revolve around training for specific situations such as breaking bad news, genetic counseling, handling special situations etc. [13]. Training in generic competencies of doctor-patient communication, such as making a patient comfortable and free to express their thoughts, effective interviewing, active listening, discussion of treatment options are often overlooked or it is presumed that they have been taught as part of clinical history taking and management [1]. As suggested in ***Table* II**, in the initial years, students should be trained in basic interviewing skills. They should gradually be moved to training in handling specific situations in subsequent clinical years. A similar building - block approach to gradually developing a hierarchy of skills has also been recommended previously [50].

Several medical schools have now established communication skills laboratories on the lines of clinical skills laboratories [51]. It is important to create learning opportunities within the curriculum where students receive feedback to inculcate communication skills [9].

ASSESSMENT OF COMMUNICATION SKILLS

Assessment can be conducted both in an artificial examination - like situation and in an authentic workplace situation. A combination of the two is perhaps most desirable. Assessment in examination situations provides students appropriate timely feedback, and stimuli to improve. When conducted in a workplace situation with observed feedback, assessment gives students practice in different clinical contexts in a non-threatening environment.

Assessment of communication skills can be designed to conform to the desired level of the Miller's pyramid [52]. While written assessments can theoretically test the 'knows' and 'knows how' levels, there is little point in granting much interpretative value to these tests, as the communication skills of a person are more a result of his attitude and behavior than his knowledge. It is more relevant to assess what a student is likely to do ('shows how') or what he actually does ('does') in a certain situation. This requires careful observation of student behavior. Several methods such as Objective Structured Clinical Examination (OSCE), Mini-clinical Evaluation Exercise (mini-CEX), videotaped doctor-patient interactions, Multisource feedback and observed encounters with simulated patients have been used for assessing communication skills [2,53,54]. Both, OSCE and mini-CEX are feasible, versatile and efficient in settings with significant clinical workload.

The OSCE conforms to the level 3 ('shows how') of Miller's pyramid and works well for formative assessment as well as for summative assessment. When designing OSCE stations, it is recommended to have integrated stations where several competencies are assessed

together. Communication skills are highly contextual (e.g., talking about introducing semisolids in diet is totally different from talking about the need for adopting family planning methods), and therefore assessment should be conducted contextually rather than in isolated communication OSCE stations. Communication skills can be tested at the history taking, physical examination and counseling stations [27, 55]. Global rating scales are preferred to checklists when assessing communication skills.

Mini-CEX is another versatile method suited to observing multiple real-life clinical encounters in the out-patient, in-patient and emergency settings. It assesses performance and action rather than competence, and includes the provision for immediate feedback. The standard rating form used in mini-CEX encounter has at least three items that contribute to assessment of communication skills (medical interviewing skills, humanistic qualities/professionalism, counseling skills). Multiple observations by multiple faculty members will provide reliability to the assessment. Its use in India has already been reported [56]. The potential of mini-CEX to assess communication skills is perhaps yet underutilized and deserves the attention of medical teachers.

Rating tools and feedback: Many assessment tools have been developed which can be used by students themselves (self-reporting scales), external raters (or observing faculty) or by patients. The evaluation criteria for these scales are based on the Kalamazoo Consensus Statement that defines seven essential elements of physician-patient communication [54].The selection or designing of an assessment tool must be done in accordance with the objectives, elements to be tested, the users, and the context. More than anything else, it requires moving away from staunch 'objectivity' in assessment; and instead, incorporating the crucial 'subjective' component of expert opinion. Multiple assessments by multiple assessors using multiple contexts have been shown to be more reliable despite being 'subjective' in the traditional sense. In the present Indian context, formative assessments provide the best opportunity for assessing communication skills and providing developmental feedback to the students. Their inclusion in the summative assessment and the weightage allotted to them need to be worked out through consensus.

FACULTY TRAINING

Faculty must develop a consensus on which component skills of communication are to be tested before choosing the appropriate combination of assessment methods for the purpose. The assessors must be trained in their jobs and the tools to be used must be validated before use. A logical approach for communication skills training is to include stakeholders who are most directly involved – the students, the faculty, and the patients [54]. Trainers for com-munications skills can be medical school faculty from multiple disciplines, specialists in communication such as psychologists with interest in medical sciences or general practitioners with an interest in medical communication [1,57]. In addition, nurses, paramedical staff or trained personnel can be used in selected situations. Assessors should not only be trained in use of assessment tools, but also in the skill of observation and feedback. A standard workshop-based training of trainers needs to be developed based on national needs. This should provide faculty trainers with the background and practice on facilitation skills [58].This will also promote use of standard training and assessment practices that are essential to sustain learning. Faculty development sessions are also desirable for all faculty members of medical schools since it increases their self-awareness as teachers [59].

TRANSFER OF SKILLS TO THE WORKPLACE

One challenge with formal communication skills training in medical schools is the gap that students observe between the communication patterns taught in training situations and the actual behavior of physicians in clinical settings [60]. This can be a major barrier to transfer of training. A possible strategy to remove this barrier could be integration of clinical and communication skills teaching in clinical situations.

Further, faculty members have to be sensitized to the 'hidden curriculum' and must be aware that they are role models who are knowingly or unknowingly imparting training in communication skills while providing clinical care.

Having good communication skills is the cornerstone of being a good physician. Teaching and assessment of communication skills need to be consciously promoted by faculty of all disciplines during undergraduate training. Further, unless assessment of communication skills is emphasized both in workplace and examination settings throughout the medical curriculum, these will be relegated to a forgotten corner.

Contributors: TS: conceptualized the paper; JC, JNM, Anshu and TS: wrote the manuscript; PG: critically reviewed.
Funding: None; *Competing interests*: None stated.

REFERENCES

1. Deveugele M, Derese A, De Maesschalck S, Willems S, van Driel M, De Maeseneer J. Teaching communication skills to medical students, a challenge in the curriculum? Patient Educ Couns. 2005;58:265-70.

2. Rider EA, Hinrichs MM, Lown BA. A model for communication skills assessment across the undergraduate curriculum. Med Teach. 2006;28:127-34.
3. Laidlaw A, Hart J. Communication skills: An essential component of medical curricula. Part I: Assessment of clinical communication: AMEE Guide No.51. Med Teach. 2011;33:6-8.
4. Tamblyn R, Abrahamowicz M, Dauphinee D, Wenghover E, Jacques A, Klass D, *et al*. Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. J Am Med Assoc. 2007;298:993-1001.
5. Shendurnikar N, Thakkar PA. Communication skills to ensure patient satisfaction. Indian J Pediatr. 2013;80: 938-43.
6. Rowland-Morin PA, Carroll JG. Verbal communication skills and patient satisfaction. Eval Health Prof. 1990;13:168-85.
7. Silverman J, Kinnersley P. Doctors' non-verbal behavior in consultations: look at the patient before you look at the computer. Br J Gen Pract. 2010;60:76-8.
8. Mehta PN. Communication skills – Talking to parents. Indian Pediatr. 2008; 45:300-4.
9. Anshu, Singh T. The art of talking to patients. *In*: Patwari AK, Sachdev HPS (editors) Frontiers in Social Pediatrics. New Delhi: Jaypee Brothers; 2016.p.199-209.
10. Aspegren K, Lonberg-Madsen P. Which basic communication skills in medicine are learnt spontaneously and which need to be taught and trained? Med Teach. 2005;27:539-43.
11. Gaufberg EH, Batalden M, Sands R, Bell SK. The hidden curriculum: What can we learn from third-year medical student narrative reflections? Acad Med. 2010;85:1710-6.
12. Benbassat J. Undesirable features of the medical learning environment: A narrative review of the literature. Adv Health SciEduc Theory Pract. 2013;18: 527-36.
13. Laidlaw TS, MacLeod H, Kaufman DM, Langille DB, Sargeant J. Implementing a communication skills programme in medical school: Needs assessment and programme change. Med Educ. 2002;36:115-24.
14. Learning objectives for medical student education. Medical School Objectives Project. Washington DC: Association of American Medical Colleges; 1998.
15. Simpson J, Furnace J, Crosby J, Cumming A, Evans P, Friedman M, *et al*. The Scottish doctor – learning outcomes for the medical undergraduate in Scotland: A foundation for competent and reflective practice. Med Teach. 2002;24:136–43.
16. General Medical Council. Tomorrow's doctors: Outcomes and standards for undergraduate medical education. London: GMC. 2009. Available from: *http://www.gmc-uk.org/Tomorrow_s_Doctors_1214.pdf_48905759.pdf*. Accessed October 3, 2015.
17. Keller V, Carroll JG. A new model for physician-patient communication. Patient Educ Couns. 1994;23:131-40.
18. Novack DH, Dube C, Goldstein MG. Teaching medical interviewing: a basic course on interviewing and the physician - patient relationship. Arch Intern Med. 1992;152:1814-20.
19. Kurtz SM, Silverman JD. The Calgary-Cambridge referenced observation guides: An aid to defining the curriculum and organizing the teaching in communication training programmes. Med Educ. 1996;30:83-9.
20. Stewart M, Brown JB, Weston WW, Mc Whinney IR, Mc William CL, Freeman TR. Patient-Centered Medicine: Transforming the Clinical Method. Thousand Oaks, 3rdedn, London: Radcliffe Publishing Ltd;2014.
21. Makoul G. Communication research in medical education. *In*: Jackson L, Duffy BK (eds). Health Communication Research: A Guide to Developments and Directions. Westport, CT: Greenwood Press; 1998.p.17-35.
22. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Acad Med. 2001;76:390-3.
23. Accreditation Council for Graduate Medical Education. General Competencies: ACGME Outcome Project 2001. Available from: *http://umm.edu/professionals/gme/competencies*. Accessed October 3, 2015.
24. The Royal College of Physicians and Surgeons of Canada. The Can MEDS 2005 Physician Competency Framework. Ottawa, Canada. Royal College of Physicians and Surgeons of Canada; 2005. Available from: *http://www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/resources/publications/framework_full_e.pdf*. Accessed October 3, 2015
25. Regulations on Graduate Medical Education 1997. Medical Council of India. Available from: *http://www.mciindia.org/Rules-and-Regulation/GME_REGULATIONS.pdf*. Accessed October 3, 2015.
26. Sood R, Adkoli BV. Medical education in India- Problems and prospects. J Indian Acad Clin Med. 2000;1:210-2.
27. Verma M, Singh T. Communication skills for clinical practice: Fad or necessity? Indian Pediatr. 1994;31:237-8.
28. Chhatwal J. Creating a demand for communication skills training in India. Med Educ.2009;43:478.
29. Supe AN. Interns' perspective about communicating bad news to patients: A qualitative study. Educ Health. 2011;24:541.
30. Choudhary A, Gupta V. Teaching communication skills to medical students: Introducing the fine art of medical practice. Int J App Basic Med Res. 2015;5:41-4.
31. Vision 2015. Medical Council of India. 2011. Available from:*http://www.mciindia.org/tools/announcement/MCI_booklet.pdf*. Accessed September 28 , 2015.
32. van Dalen J, Kerkhofs E, van Knippenberg-van Den Berg BW, van Den Hout HA, Scherpbier AJ, van der Vleuten CPM. Longitudinal and concentrated communication skills programmes: Two Dutch medical schools compared. Adv Health Sci Educ Theor Pract. 2002; 7:29-40.
33. Medical Council of India. Sensitization Program on Attitude and Communication Module (AT-COM). MCI decisions on MET. 2015. Available from: *http://www.mciindia.org/fdp/MCI_decisions_on_MET.pdf*. Accessed October 3, 2015.
34. Rosenbaum ME, Ferguson KJ, Lobas JG. Teaching medical students and residents skills for delivering bad news: A review of strategies. Acad Med. 2004;79:107-17.

35. Brown RF, Bylund CL. Communication skills training: Describing a new conceptual model. Acad Med. 2008;83:37-44.
36. Aspegren K. BEME Guide no. 2: Teaching and learning communication skills in medicine – a review with quality grading of articles. Med Teach. 1999;2: 563-70.
37. Shapiro SM, Lancee WJ, Richards-Bentley CM. Evaluation of a communication skills program for first-year medical students at the University of Toronto. BMC Med Educ. 2009;9:11.
38. Rees C, Sheard C, McPherson A. Medical students' views and experiences of methods of teaching and learning communication skills. Patient Educ Couns. 2004;54: 119-21.
39. Hurtubise L, Martin B, Gilliland A, Mahan J. To play or not to play: Leveraging video in medical education. J Grad Med Educ. 2013;5:13-8.
40. Linssen T, van Dalen J, Rethans JJ. Simulating the longitudinal doctor-patient relationship: experiences of simulated patients in successive consultations. Med Educ. 2007;41:873-8.
41. Liew SC, Dutta S, Sidhu JK, De-Alwis R, Chen N, Sow CF, *et al*. Assessors for communication skills: Simulated patients or healthcare professionals? Med Teach. 2014;36:626-31.
42. Jackson, VA, Back AL, Teaching communication skills using role-play: An experience based guide for educators. J Palliat Med. 2011;14:775-80.
43. Luttenberger K, Graessel E, Simon C, Donath C. From board to bedside- training the communication competencies of medical students with role plays. BMC Med Educ. 2014;14:135.
44. Anderson AD, Dow AW. Teaching empathy to physicians. *In:* Scapaleti DJ, editor. The Psychology of Empathy. New York: Nova Science Publishers; 2011.p.267-80.
45. Gupta S, Agrawal A, Singh S, Singh N. Theatre of the oppressed in medical humanities education: The road less travelled. Indian J Med Ethics. 2013;10: 200-3.
46. D' Ardis M. Forum theatre for practice simulation and skills development in nurse education: A student's perspective. Nurse Educ Today. 2014;34:1136-7.
47. Middlewick Y, Kettle TJ, Wilson JJ. Curtains up! Using forum theatre to rehearse the art of communication in healthcare education. Nurse Educ Pract. 2012;12:139-42.
48. Dasgupta S. Between stillness and story: lessons of children's illness narratives. Pediatrics. 2007;119:e 1384-91.
49. McNeilly P, Read S, Price J. The use of biographies and stories in paediatric palliative care education. Int J Palliat Nurs. 2008;14:402-6.
50. Epner DE, Baile WF. Wooden's pyramid: Building a hierarchy of skills for successful communication. Med Teach. 2011;33: 39-43.
51. Salvatori P, Mahoney P, Delottinville C. An interprofessional communication skills lab: A pilot project. Educ Health. 2006;19:380-84.
52. Miller GE. The assessment of clinical skills/competence/ performance. Acad Med. 1990:65:S63-7.
53. Baig LA, Violato C, Crutcher RA. Assessing clinical communication skills in physicians: are the skills context specific or generalizable? BMC Med Educ. 2009;9:22.
54. Schirmer JM, Mauksch L, Lang F, Marvel MK, Zoppi K, Epstein RM, *et al* Assessing communication competence: A review of current tools. Fam Med. 2005;37:184-92.
55. Gupta P, Dewan P, Singh T. Objective Structured Clinical Examination (OSCE) revisited. Indian Pediatr. 2010;47:911-20.
56. Singh T, Sharma M. Mini-clinical examination (CEX) as a tool for formative assessment. Natl Med J India. 2010; 23:100-2.
57. Shankar PR, Dubey AK, Mishra P, Deshpande VY, Chandrashekhar TS, Shivananda PG. Student attitudes towards communication skills training in a medical college in Western Nepal. Educ Health. 2006;19:71-84.
58. Bylund CL, Brown RF, diCoccone BL, Levin TT, Gueguen JA, Hill C, *et al*. Training faculty to facilitate communication skills training: development and evaluation of workshop. Patient Educ Couns. 2008;70:430-6.
59. Bird J, Hall A, Maguire P, Heavy A. Workshops for consultants on teaching of clinical communication skills. Med Educ. 1993; 27:181-5.
60. Essers G, van Weel-Baumgarten E, Bolhuis S. Mixed messages in learning communication skills? Students comparing role model behavior in clerkships with formal training. Med Teach. 2012;34:e659-65.