How to Facilitate Communication Sessions at the MD Program - Faculty Development Video (2025)

TITLE SLIDE – Facilitator Guide to Teaching Communication Sessions

Thank you for agreeing to facilitate communication sessions and being involved in mentoring and teaching medical students at the MD Program. This short video will highlight the teaching expectations and most important aspects of how to run these communication sessions.

SLIDE TWO: Objectives

- The objectives of this short video are to briefly describe the structure and purpose of the communications curriculum. Furthermore, the 4 steps of how to prepare and facilitate these sessions will be discussed and include how each session is organized, review of the teaching materials, the logistics of how to facilitate each session and guidelines for assessing learners.

SLIDE THREE: What ARE communication sessions?

- The purpose of communication sessions is for medical learners to learn how to perform a medical interview, a foundational skill that all physicians must develop to be successful in the career.
- Communication sessions are a mandatory part of the MD Program curriculum at the University of Alberta and encompasses all 4 years. For each session, facilitators will be teaching the same content twice over 4 hours, working with 2 groups of 4 students. For example, a facilitator may lead the first group of 4 students from 1 till 3 PM, and the next group from 3 until 5 PM.
- Medical students learn how to take a history while building a relationship. They also learn how to discuss the potential diagnoses using shared decision-making strategies as delineated in the RESPECT framework. The RESPECT framework, attached to the facilitator guide, is taught to the medical students in a lecture before attending their first communication session with you.
- At most of these sessions, students are each assigned a different case to role-play, and take turns being interviewed by their peer such that each student plays the patient once and interviews once.
- Be aware that not all sessions are the same! Some sessions will employ standardized patients (called SP's) who role-play patients that students will interview. Other sessions may require that students practice their physical exam, perform case presentations or have clinical decision-making or management discussions after each case scenario.

SLIDE FOUR: Communication Sessions Curriculum Overview

- Medical students receive a lecture on how to take a history and will review the 3 parts of the medical interview which are 1) gathering information 2) building a relationship and 3) educating the patient and collaborating on a management plan. These concepts are taught during their Foundations block of Year 1. Year 1 also includes teaching

students on the specifics of how to take a geriatric and pediatric history, as well as cases centred around cardiopulmonary based presentations that mirror the block content taught in Year 1, the year finishes with a practice then formative communications OSCE.

- In Year 2, communication sessions again mirror the medical expert block content including how to take a prenatal history, a sexual history, as well as histories centred around a gastrointestinal, muscular or neurologic complaint. As Oncology is taught in year 2, there is a communication session on 'how to break bad news'. Year 2 finishes with a 3 station summative communications OSCE.
- Year 3 sees medical students leaving lecture halls and beginning their clinical experiences on the wards or in clinics, and as such, topics of advanced care planning, error disclosure, conflict negotiation, and verbal handovers of patient care are relevant topics for communication sessions.
- Motivational interviewing is the topic for history taking practice in Year 4 communication sessions.
- The asterisk denotes sessions where case presentations are emphasized as students need practice of this important skill before they hit the wards and clinics. The letters SP denotes sessions where standardized patients are employed to role-play the patient. Recognize that having standardized patients necessitates that facilitators have appropriate time management as the SP often rotates from room to room.
- Consolidation cases in Year 1 and 2 are different in that the student group sizes are much larger, and that standardized patients are employed to play a SINGLE case with a group effort in history taking, physical exam and discussion of case approach and management.

SLIDE FIVE: How to prepare to facilitate communication session:

- In this next section, we will discuss how the communication sessions are organized, what the teaching materials look like and when they will be emailed to you. Furthermore, the logistics of how to facilitate each session as well as how to assess learners during each session will be discussed.

SLIDE SIX: 1. Session Organization

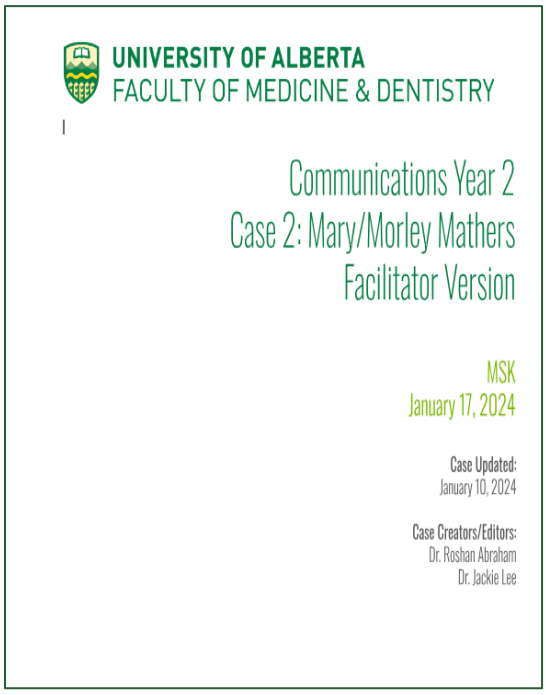
- The MD program decides on curriculum content and schedules each of the sessions and assigns the cases to the medical students and provides the physical space for the communication sessions, typically located in Health Education Centre in the Grande Prairie Regional Hospital, or the small group rooms located in the Katz building on UA campus.
- Facilitators are generalist clinicians, family physicians and senior family medicine residents recruited several months in advance either by NAMP administrators or through Department of Family Medicine (email: ugfm@ualberta.ca). Calendar invites are usually sent out several weeks in advance of each communication session.

SLIDE SEVEN: 2. Teaching Materials

- Expect to receive an email from the MD Program with the facilitator teaching materials, the group you have been assigned and your physical location of the communication session ONE WEEK in advance of your session. Links to complete assessments of your medical students in assess.med.ualberta.ca usually are emailed to you the DAY of the session. Please plan to bring a computer or tablet to the session so that you can complete the learner assessments in real-time on the day of the session. *You will need your CCID and password in order to access the assessments.*
- It is suggested that you read through the facilitator notes and explore the helpful hyperlinks that may help you with the specific learning objectives and discussion points. The overall anticipated preparation time for the average communication session should be less than 1 hour if it is the first time you are teaching this. Please take note of whether the session employs standardized patients as the timekeeping becomes crucial in order for the sessions to run smoothly.
- Familiarize yourself with the cases, but there is NO expectation to learn the cases as medical students or standardized patients will role-play cases as assigned.
- The ONLY time facilitators are expected to learn 4 short cases are the year 3 conflict negotiation/error disclosure cases: this is ALSO the only time where communication sessions are held VIRTUALLY. All other communication sessions are held IN person with the students or SP's learning the role-plays.

SLIDE EIGHT: 2. Teaching Materials (example)

- Here are some screenshots of what the typical cover page and facilitator notes might look like, with hyperlinks that you could click on to enrich your knowledge for case discussion. As a reminder, facilitators are not expected to create or add to the facilitator guide. It is important to teach from the source material to ensure consistency and the meeting of learning objectives from group to group.

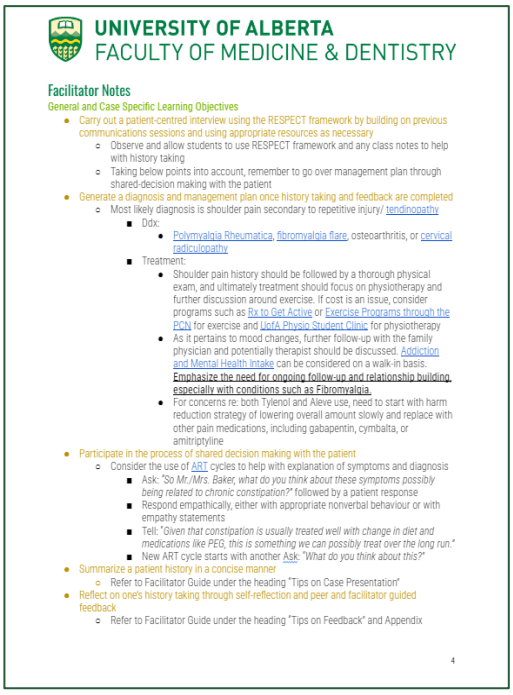

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Communications Year 2
Case 2: Mary/Morley Mathers
Facilitator Version

MSK
January 17, 2024

Case Updated:
January 10, 2024

Case Creators/Editors:
Dr. Roshan Abraham
Dr. Jackie Lee


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Facilitator Notes

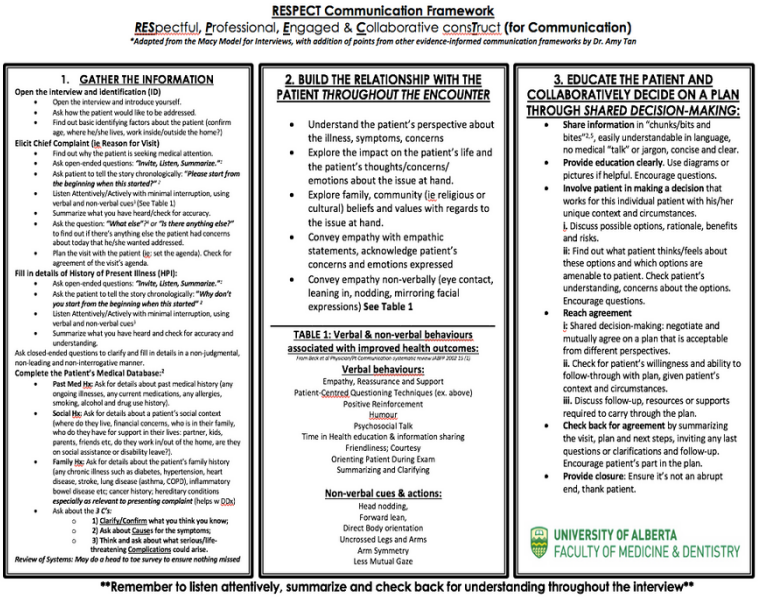
General and Case Specific Learning Objectives

- Carry out a patient-centred interview using the RESPECT framework by building on previous communications sessions and using appropriate resources as necessary
  - Observe and allow students to use RESPECT framework and any class notes to help with history taking
  - Taking below points into account, remember to go over management plan through shared-decision making with the patient
- Generate a diagnosis and management plan once history taking and feedback are completed
  - Most likely diagnosis is shoulder pain secondary to repetitive injury/ tendinopathy
    - Ddx:
      - Polymyalgia Rheumatica, fibromyalgia flare, osteoarthritis, or cervical radiculopathy
    - Treatment:
      - Shoulder pain history should be followed by a thorough physical exam, and ultimately treatment should focus on physiotherapy and further discussion around exercise. If cost is an issue, consider programs such as Rx to Get Active or Exercise Programs through the PCN for exercise and UofA Physio Student Clinic for physiotherapy
      - As it pertains to mood changes, further follow-up with the family physician and potentially therapist should be discussed. Addiction and Mental Health Intake can be considered on a walk-in basis. Emphasize the need for ongoing follow-up and relationship building, especially with conditions such as Fibromyalgia.
      - For concerns re: both Tylenol and Aleve use, need to start with harm reduction strategy of lowering overall amount slowly and replace with other pain medications, including gabapentin, cymbalta, or amitriptyline
- Participate in the process of shared decision making with the patient
  - Consider the use of ART cycles to help with explanation of symptoms and diagnosis
    - Ask: *"So Mr./Mrs. Baker, what do you think about these symptoms possibly being related to chronic constipation?"* followed by a patient response
    - Respond empathically, either with appropriate nonverbal behaviour or with empathy statements
    - Tell: *"Given that constipation is usually treated well with change in diet and medications like PEG, this is something we can possibly treat over the long run."*
    - New ART cycle starts with another Ask: *"What do you think about this?"*
- Summarize a patient history in a concise manner
  - Refer to Facilitator Guide under the heading "Tips on Case Presentation"
- Reflect on one's history taking through self-reflection and peer and facilitator guided feedback
  - Refer to Facilitator Guide under the heading "Tips on Feedback" and Appendix

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SLIDE NINE: 3. Logistics of running communication sessions

- All communication sessions with the exception of the virtual year 3 conflict negotiation and error disclosure cases, are 4 hours in duration where facilitators will have 2 groups of 4 students each, running the same cases and discussions twice. The typical time slots for each group would be 8 AM to 9:50 AM, then 10 AM until 11:50 AM. For afternoon sessions, the first group of students would arrive at 1 PM, and the second group of students would arrive at 3 PM.
- In each session, students will be assigned to learn one of four clinical cases. The 4 students will rotate amongst themselves such that they will each role-play the patient once and interview as a physician once.
- Medical students are given lectures in advance of the communication sessions on the RESPECT framework which outlines how to take a history, build a relationship and educate the patient through shared decision-making.



RESPECT Communication Framework

RESpectful, **P**rofessional, **E**ngaged & **C**ollaborative cons**T**ruct **(for Communication)**

**Adapted from the Macy Model for Interviews, with addition of points from other evidence-informed communication frameworks by Dr. Amy Tan*

1. GATHER THE INFORMATION

Open the interview and identification (ID)

- Open the interview and introduce yourself.
- Ask how the patient would like to be addressed.
- Find out basic identifying factors about the patient (confirm age, where he/she lives, work inside/outside the home?)

Elicit Chief Complaint (ie Reason for Visit)

- Find out why the patient is seeking medical attention.
- Ask open-ended questions: ***"Invite, Listen, Summarize."***[1]
- Ask patient to tell the story chronologically: ***"Please start from the beginning when this started?"***[2]
- Listen Attentively/Actively with minimal interruption, using verbal and non-verbal cues[3] (See Table 1)
- Summarize what you have heard/check for accuracy.
- Ask the question: ***"What else?"*** or ***"Is there anything else?"*** to find out if there's anything else the patient had concerns about today that he/she wanted addressed.
- Plan the visit with the patient (ie: set the agenda). Check for agreement of the visit's agenda.

Fill in details of History of Present Illness (HPI):

- Ask open-ended questions: ***"Invite, Listen, Summarize."***[1]
- Ask the patient to tell the story chronologically: ***"Why don't you start from the beginning when this started"***[2]
- Listen Attentively/Actively with minimal interruption, using verbal and non-verbal cues[3]
- Summarize what you have heard and check for accuracy and understanding.

Ask closed-ended questions to clarify and fill in details in a non-judgmental, non-leading and non-interrogative manner.

Complete the Patient's Medical Database:[3]

- **Past Med Hx:** Ask for details about past medical history (any ongoing illnesses, any current medications, any allergies, smoking, alcohol and drug use history).
- **Social Hx:** Ask for details about a patient's social context (where do they live, financial concerns, who is in their family, who do they have for support in their lives: partner, kids, parents, friends etc, do they work in/out of the home, are they on social assistance or disability leave?).
- **Family Hx:** Ask for details about the patient's family history (any chronic illness such as diabetes, hypertension, heart disease, stroke, lung disease (asthma, COPD), inflammatory bowel disease etc; cancer history; hereditary conditions ***especially as relevant to presenting complaint*** (helps w DDx)
- Ask about the ***3 C's***:
  - **1) Clarify/Confirm what you think you know;**
  - **2) Ask about Causes for the symptoms;**
  - **3) Think and ask about what serious/life-threatening Complications could arise.**

Review of Systems: May do a head to toe survey to ensure nothing missed

2. BUILD THE RELATIONSHIP WITH THE PATIENT *THROUGHOUT THE ENCOUNTER*

- Understand the patient's perspective about the illness, symptoms, concerns
- Explore the impact on the patient's life and the patient's thoughts/concerns/ emotions about the issue at hand.
- Explore family, community (ie religious or cultural) beliefs and values with regards to the issue at hand.
- Convey empathy with empathic statements, acknowledge patient's concerns and emotions expressed
- Convey empathy non-verbally (eye contact, leaning in, nodding, mirroring facial expressions) **See Table 1**

TABLE 1: Verbal & non-verbal behaviours associated with improved health outcomes:

From Beck et al Physician/Pt Communication systematic review JABFP 2002 15 (1)

Verbal behaviours:

Empathy, Reassurance and Support
Patient-Centred Questioning Techniques (ex. above)
Positive Reinforcement
Humour
Psychosocial Talk
Time in Health education & information sharing
Friendliness; Courtesy
Orienting Patient During Exam
Summarizing and Clarifying

Non-verbal cues & actions:

Head nodding,
Forward lean,
Direct Body orientation
Uncrossed Legs and Arms
Arm Symmetry
Less Mutual Gaze

3. EDUCATE THE PATIENT AND COLLABORATIVELY DECIDE ON A PLAN THROUGH *SHARED DECISION-MAKING*:

- **Share information** in "chunks/bits and bites"[2,5], easily understandable in language, no medical "talk" or jargon, concise and clear.
- **Provide education clearly.** Use diagrams or pictures if helpful. Encourage questions.
- **Involve patient in making a decision** that works for this individual patient with his/her unique context and circumstances.
  i. Discuss possible options, rationale, benefits and risks.
  ii: Find out what patient thinks/feels about these options and which options are amenable to patient. Check patient's understanding, concerns about the options. Encourage questions.
- **Reach agreement**
  i: Shared decision-making: negotiate and mutually agree on a plan that is acceptable from different perspectives.
  ii. Check for patient's willingness and ability to follow-through with plan, given patient's context and circumstances.
  iii. Discuss follow-up, resources or supports required to carry through the plan.
- **Check back for agreement** by summarizing the visit, plan and next steps, inviting any last questions or clarifications and follow-up. Encourage patient's part in the plan.
- **Provide closure**: Ensure it's not an abrupt end, thank patient.

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****Remember to listen attentively, summarize and check back for understanding throughout the interview****

SLIDE TEN: 3. Logistics of running communication sessions (introductions)

- At the start of each session, please introduce yourself, and have learners introduce themselves. Review the session objectives and the expected format.
- Designate a student to watch the time. Review who will be role-playing and who will take the history, ensure the rotation of students into these roles result in each student having a chance to role-play once, and interview once.
- Set up ground rules for feedback and discussions.

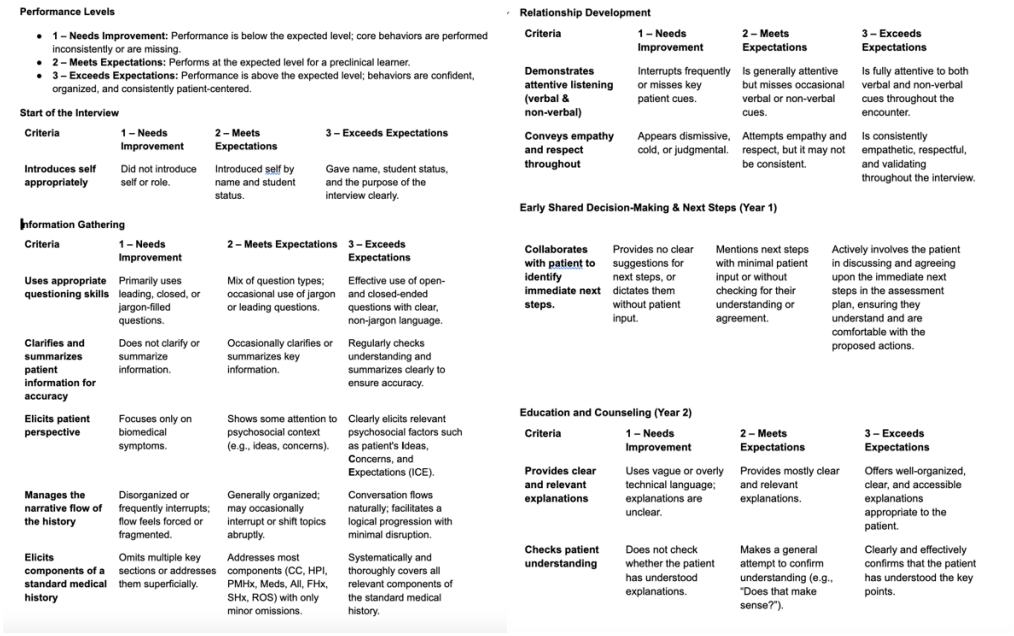
- Prioritize specific learning objectives as set out in the teaching materials. For example, some sessions focus on case presentations practice while other sessions might focus on a discussion of the clinical decision-making matrix.

SLIDE ELEVEN: 3. Logistics of running communication sessions (timing, structure)

- For most communication sessions, allot 25 minutes for each case, which is broken down into 15 minutes of interview time for each student, followed by 10 minutes for case discussion and case summary presentation. Case presentations are not formally required until Year 2 communication sessions, but always worth practicing even in Year 1 as this is a vital skill that medical students need to develop.
- Feedback on the interview scenario could begin with self-reflection of the interviewer followed by having the student role-playing the case providing feedback. Subsequently, the 2 students observing the encounter can then provide feedback. Be aware that students are taught how to give constructive feedback to each other, and peer feedback is an expected part of their learning. Lastly, you can provide any additional feedback as well as teaching to the objectives detailed in the facilitator notes. This might include a brief review of the clinical decision matrix, or focus of case presentations, or discussion of next management steps.

SLIDE TWELVE: 4. Assessing Learners

- You will receive a link prior to the session. This link, accessible with your CCID and password will take you to assess.med.ualberta.ca where your 8 student names will be listed.
- Please bring your laptop or tablet so you can complete the 10-12-point assessment as the interview progresses. Facilitators score the student with a choice of 3 numbers, **1** meaning the student needs improvement, **2** correlates with the student meeting expectations, **3** suggesting that the student exceeds expectations on the various components of the interview. Components to be scored on include whether students introduced themselves, had good verbal and non-verbal communication skills, whether they collaborated with and educated patients and whether they closed the interview effectively.



Performance Levels

- **1 – Needs Improvement:** Performance is below the expected level; core behaviors are performed inconsistently or are missing.
- **2 – Meets Expectations:** Performs at the expected level for a preclinical learner.
- **3 – Exceeds Expectations:** Performance is above the expected level; behaviors are confident, organized, and consistently patient-centered.

Start of the Interview

Criteria	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations
Introduces self appropriately	Did not introduce self or role.	Introduced self by name and student status.	Gave name, student status, and the purpose of the interview clearly.

Information Gathering

Criteria	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations
Uses appropriate questioning skills	Primarily uses leading, closed, or jargon-filled questions.	Mix of question types; occasional use of jargon or leading questions.	Effective use of open- and closed-ended questions with clear, non-jargon language.
Clarifies and summarizes patient information for accuracy	Does not clarify or summarize information.	Occasionally clarifies or summarizes key information.	Regularly checks understanding and summarizes clearly to ensure accuracy.
Elicits patient perspective	Focuses only on biomedical symptoms.	Shows some attention to psychosocial context (e.g., ideas, concerns).	Clearly elicits relevant psychosocial factors such as patient's Ideas, Concerns, and Expectations (ICE).
Manages the narrative flow of the history	Disorganized or frequently interrupts; flow feels forced or fragmented.	Generally organized; may occasionally interrupt or shift topics abruptly.	Conversation flows naturally; facilitates a logical progression with minimal disruption.
Elicits components of a standard medical history	Omits multiple key sections or addresses them superficially.	Addresses most components (CC, HPI, PMHx, Meds, All, FHx, SHx, ROS) with only minor omissions.	Systematically and thoroughly covers all relevant components of the standard medical history.

Relationship Development

Criteria	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations
Demonstrates attentive listening (verbal & non-verbal)	Interrupts frequently or misses key patient cues.	Is generally attentive but misses occasional verbal or non-verbal cues.	Is fully attentive to both verbal and non-verbal cues throughout the encounter.
Conveys empathy and respect throughout	Appears dismissive, cold, or judgmental.	Attempts empathy and respect, but it may not be consistent.	Is consistently empathetic, respectful, and validating throughout the interview.

Early Shared Decision-Making & Next Steps (Year 1)

Collaborates with patient to identify immediate next steps.	Provides no clear suggestions for next steps, or dictates them without patient input.	Mentions next steps with minimal patient input or without checking for their understanding or agreement.	Actively involves the patient in discussing and agreeing upon the immediate next steps in the assessment plan, ensuring they understand and are comfortable with the proposed actions.

Education and Counseling (Year 2)

Criteria	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations
Provides clear and relevant explanations	Uses vague or overly technical language; explanations are unclear.	Provides mostly clear and relevant explanations.	Offers well-organized, clear, and accessible explanations appropriate to the patient.
Checks patient understanding	Does not check whether the patient has understood explanations.	Makes a general attempt to confirm understanding (e.g., "Does that make sense?").	Clearly and effectively confirms that the patient has understood the key points.

Close the Interview (Year 2)

Criteria	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations
Collaborates with patient to identify next steps for management	Dictates next steps without involving the patient.	Mentions clear steps for management with minimal patient input.	Actively involves the patient in identifying and agreeing upon the next steps for management.
Overall Impression (Years 1-4)	1 – Needs Improvement	2 – Meets Expectations	3 – Exceeds Expectations

SLIDE THIRTEEN: 4. Assessing Learners (how do students pass)

- Please be aware that completing the 10-12-point assessment that is completed during each communication session is formative, used by students to improve their interview and communication skills. Mark the students as you see fit, contextualizing where they are in their training. For example, Year 1 and 2 medical students will have had minimal patient contact and will be less experienced in their history taking, ability to build rapport or develop case summaries or management plans. However, if you assess that the student needs improvement, please do not hesitate in providing an overall mark of 'Needs Improvement' as this will assist coordinators in providing earlier assistance for students. Your assessment will not result in your students failing.
- The requirements to pass communication sessions is based on attendance and how medical students perform on an OSCE. Attendance is tracked by having students scan a QR code when they enter the small group rooms. Communication skills are assessed through a practice and formative OSCE at the end of year 1, and a summative OSCE at the end of Year 2 *where students must pass 2 of 3 communication OSCE stations*.
- Failure will result in students writing a remedial OSCE in mid-July.
- Failure of a 2nd OSCE will result in a review by Academic Standings and the formulation of a formal remediation plan before a decision can be made for allowing students to advance into year 3.

SLIDE FOURTEEN: Take Home Points

- Expect to receive your teaching materials one week prior to the session. In preparation, familiarize yourself with the cases, and mainly the primary objectives of the session (such as case presentations, clinical reasoning or management)
- Most sessions are in person and consist of 4 students to one facilitator where each student role-plays a case, and a fellow student interviews. This is done in rotation, so each learner has an opportunity to role-play and interview. Some sessions have standardized patients playing the cases instead. Only the year 3 error disclosure and conflict negotiation cases require facilitators to learn the cases and role-play, this is also the only session held virtually.
- Please have a student time-keep the sessions so all students have equal opportunity to role-play, interview, give and receive feedback and discuss the pertinent portions of the case as per facilitator instructions
- Most importantly, enjoy your teaching experience! Students have traditionally rated the communications curriculum very highly, as this is their opportunity to learn from experienced clinicians and mentors like yourself.

SLIDE FIFTEEN: Leading with Purpose

Once again, many thanks for facilitating the communications curriculum. Please reach out to the course coordinators listed on the facilitator guide or your local NAMP coordinator depending on your location of work if you have any questions or concerns. Please consider logging into to Cally to check out your professor pages for other faculty development videos and orientations.