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Letter to Editor

Educational Challenges in Training Patient-Centered Communication in Senior Medical Students

Dear Editor

The global strategy of the World Health Organization (WHO) on integrated people-centered healthcare has heightened the focus on patient-centered communication (PCC) skills training for healthcare providers and physicians. PCC skills are one of the six core competencies for physicians, which aim to improve clinical outcomes and patient adherence, as effective healthcare delivery relies on strong physician-patient communication.[1]

With the widespread prevalence of chronic diseases, such as diabetes, hypertension, coronary artery disease, and cancers, effective PCC skills are critical. Involving patients in decision-making enhances treatment cooperation, medication adherence, and healthier behaviors, which ultimately can improve the quality of life. Conversely, poor PCC skills may lead to dissatisfaction, medical errors, misdiagnoses, unnecessary costs, and complaints. These issues are often associated with substandard PCC skills, including inadequate listening and response, incomplete information, or unempathetic responses.[2]

Although communication skills training is integrated into the curricula of most medical faculties, persistent rates of medical errors and dissatisfaction suggest that PCC skills remain suboptimal.

Several studies conducted in Iran and other countries reported that clinicians and medical students had insufficient PCC knowledge, and their application of it was not at an appropriate level.[3, 4] For instance, Bahraminia and Amini found that Iranian medical students performed poorly in non-verbal communication and summarizing patient interviews. They recommended the use of rating scales to assess students' communication skills more effectively and emphasized the need for prioritizing educational interventions in this area.[3]

Similarly, Gilligan and others emphasized the critical need to enhance how communication skills are taught and learned in medical education. Their research advocated for a scaffolded approach, where students first mastered foundational competencies before advancing to more sophisticated clinical communication settings.[4]

Rieffestahl and others argue that challenges in medical education systems often stem from an overemphasis on biomedical curriculum content and structure. Additionally, medical students are socialized into their roles as experts, while patients, often excluded from most of the PCC skills training, are treated as passive subjects.[5] This dynamic might hinder the development of empathy and collaboration, which are essential to PCC skills. To address this gap, the authors advocate for curricular reforms that prioritize experiential learning with real patients and reflective practices.

Various PCC training strategies in medical schools have improved short-term knowledge, but long-term retention is uncertain. For example, a survey conducted at the University of Porto, Faculty of Medicine, showed that after 3 years of clerkships, students' overall communication skills remained at a baseline level, with no significant improvement. However, notable variations were observed in specific competencies, such as empathic attitudes and information-gathering abilities.[6] Such reforms would foster meaningful patient-student interactions, bridging the gap between theoretical knowledge and clinical practice while aligning medical education with the changing nature of patient-centered healthcare.[5]

Taveira-Gomes and Mota-Cardoso demonstrated that while traditional educational interventions effectively enhanced medical students' PCC skills and knowledge, these improvements often failed to persist long-term.[6] Their findings suggest that although PCC workshops can strengthen certain dimensions of PCC, sustained proficiency requires ongoing training. To truly cultivate patient-centered attitudes and skills, medical education must incorporate practical opportunities for students to practice PCC skills in real clinical settings, coupled with structured feedback mechanisms.

Authors' Contribution

L.J: Conceptualization, study design, data gathering, drafting, and reviewing; A.DD: Conceptualization, study design, data gathering, drafting, and reviewing; SM.H: Conceptualization, study design, and reviewing; M.Y: Conceptualization, study design, data gathering, reviewing the manuscript; All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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