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PRIORITIZING COMMUNICATION SKILLS IN THE ARMENIAN UNDERGRADUATE MEDICAL EDUCATION SYSTEM

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ABSTRACT

Physicians' strong communication skills increase patient adherence to treatment plans, lead to improved treatment outcomes, and contribute to higher levels of satisfaction with their healthcare experience. However, there still persist several barriers and challenges which complicate effective communication, such as language differences, cultural diversity, and time constraints. Undergraduate medical education is the basic system for the development of future healthcare professionals.

This review article aims to elucidate communication skills teaching, learning and assessment peculiarities in modern medical education. It addresses existing barriers, proposes strategies for improvement, and suggests ways to overcome challenges in educating communication skills. By exploring various frameworks, models, and teaching strategies, it provides insights into how communication skills can be effectively integrated into current medical curricula. Special attention is given to the Armenian context.

In the Republic of Armenia, undergraduate level medical professions are regulated by a number of laws, regulations, and instruments, including: the law of Armenia on higher and postgraduate education, the listed higher education level specialties, Armenian national qualifications framework, and the "Medicine" sectoral qualifications framework. The latter two instruments cover graduates' knowledge and competency that outline communication skills as one of the key competencies. However, Armenian higher education institutions providing medical education have varying medical graduates' competences lists.

Integrating communication skills training into medical curricula is imperative to adequately equipping future physicians with necessary competences. Formalization of communication skills teaching, learning and especially assessment with the use of structured frameworks in Armenian undergraduate medical education system will obviously improve medical graduates' communication skills. An additional supra-institutional regulation instrument which describes a detailed list of essential skills and competencies for undergraduate medical professionals and centralized State licensure examinations for medical graduates in Armenia could be a promising solution.

KEYWORDS: communication skills, effective communication, doctor-patient communication, undergraduate medical education, medical curriculum, educational framework, qualification framework.

INTRODUCTION

Providing effective patient care requires a holistic approach that extends beyond diagnosing and treating the patient alone. It necessitates that doctors possess not only medical knowledge and clinical competencies but also strong communication skills. Research indicates that physicians' strong verbal, non-verbal,

"Words are, of course, the most powerful drug used by mankind."

RUDYARD KIPLING

and para-verbal communication skills increase patient adherence to treatment plans, lead to improved treatment outcomes, and contribute to higher levels of satisfaction with their healthcare experience [Joyce B et al., 2010; Ranjan P et al., 2015; Mohd

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Salim N et al., 2023; Sharkiya S, 2023]. Conversely, communication failures such as misunderstandings, misinterpretations or ambiguities can lead to patient harm and even death [JCI, 2018].

A recent World Health Organization report explores the issue that traditional education of health care professionals gives little attention to the importance of patient safety, as a consequence of which "... there is minimal emphasis on the importance of teamwork and communication in protecting patients from harm" [WHO, 2021]. Addressing patient safety, the World Health Organization underscores building competencies of health care workers and improving teamwork and communication [WHA72.6, 2019]. The US Accreditation Council for Graduate Medical Education has identified the importance of addressing cultural diversity as part of its professionalism competency [Like R, 2011].

As healthcare becomes increasingly globalized and characterized by diverse patient populations, doctors must deal with patients of different cultural, linguistic, and socio-economic backgrounds [Taylan C, Weber L, 2023]. There are still barriers and challenges, such as language differences, cultural diversity, and time constraints complicate effective communication [Al Shamsi H et al., 2020; Rukadikar C et al., 2022]. These challenges underscore the necessity for structured frameworks and models that can be adapted to different educational contexts to ensure that medical students acquire the essential communication skills [Makoul G, 2001a; Rider E et al., 2006; Brown R, Bylund C, 2008]. Given the critical role of communication in patient care, it is imperative that medical education places a strong emphasis on developing these skills.

Through a comprehensive approach to communication training, a more effective, patient-centered healthcare system worldwide can be fostered, ensuring that all medical students, including those in Armenia, acquire the essential communication skills necessary for their future roles as healthcare workers.

This paper aims to elucidate communication skills teaching, learning and assessment peculiarities in modern medical education. It addresses existing barriers, proposes strategies for improvement, and suggests ways to overcome challenges in educating communication skills. By exploring various frameworks, models, and teaching strategies, it provides insights into how communication skills can be effectively integrated into the medical curriculum. Special attention is given to the undergraduate medical education of Armenian students, highlighting how universal recommendations can be implemented on national and institutional levels.

MATERIAL AND METHODS

Literary research was conducted across internet bibliographic open-access sources using the following keywords: "communication skills", "effective communication", "doctor-patient communication", "medical education", "medical curriculum", and "educational framework".

This paper presents the key findings of a literature review encompassing published articles, reports, standards, guidelines, regulations and legal acts on communication skills in medical education, without constraints on publication dates.

RESULTS AND DISCUSSION

Categories of doctor-patient communication skills

In order to ensure clarity regarding the focus of communication skill training in undergraduate medical education, Suzanne M. Kurtz classifies the following: content skills, process skills, perceptual skills [Kurtz S, 2002; Kurtz S et al., 1998].

Content skills – what doctors say, e.g., asking questions and receiving responses from patients providing relevant information, compiling a list of potential diagnoses based on the symptoms presented, and based upon their medical knowledge, informing patients of their decisions and recommendations [Kurtz S, 2002; Mohd Salim N et al., 2023].

Process skills – how doctors communicate, including the way they ask questions, listen attentively, plan the treatment with the patient, structure their interactions, and make this structure evident to the patient through signposting or transitions, as well as how they establish relationships with patients [Kurtz S, 2002; Kurtz S et al., 1998].

Perceptual skills – During communication, doctors must remain attuned to a patient's internal cognitive and emotional states. This involves recognizing biases, one's behavior during interactions with patients, and sharing decision-making processes.

Communication is a complex phenomenon comprising a number of aspects that goes beyond simple verbal exchanges. Furthermore, there are a number of disturbing external factors that could hinder effective communication [Kurtz S et al., 1998; Mohd Salim N et al., 2023]. There is a misconception that communication is mostly about talking, explaining, and sharing information. As Borg notes, "Human communication consists of 93% body language and paralinguistic clues, while only 7% of communication consists of words themselves [Borg J, 2010].

Communication can be decoded as verbal, non-verbal and para-verbal components. Verbal communi-

cation is the interaction through the usage of words. Simply defined, non-verbal communication is communication without words through facial expressions, nodding of the head, posture, and body position. Para-verbal communication refers to the speaker's voice and includes the tone, pitch, and pacing. Effective communication in medical practice and education extends beyond verbal exchanges, encompassing non-verbal and para-verbal cues, as well as active listening and empathy which is believed to be essential clinical skill for doctors [Ranjan P et al., 2015]. Good communication is an integral part of a doctor's professional activity, starting with the first encounter with the patient, and continuing through diagnosis, treatment, and follow-up care. Those skills are found to have profound impact on doctor-patient encounters. They not only improve treatment outcomes and contribute to higher levels of satisfaction, but also help in building safe, trustworthy, supportive, and professional working environment [Schyve P, 2007; Joyce B et al., 2010; Ranjan P et al., 2015; Mohd Salim N et al., 2023].

Barriers to communication

There are some barriers to communication that need to be considered, such as the patient's race, gender, culture, language, time constraints, speech ability, illness, mental state, medication and psychological aspects [Kumar R et al., 2021]. Language barriers, arising from either limited proficiency in foreign languages or dialects by either the patient or the doctor along with the use of non-user-friendly language by medical professionals, have been identified as significant contributors to physician-patient miscommunication [Forsey J et al., 2021]. Language differences, in particular, can be significant barriers to effective information exchange among physicians and patients, often leading to frustration, anger, and sadness for both patients and their families [Ramirez A et al. 1996; Ranjan P et al., 2015]. Language barrier is the key cause of miscommunication and negatively impact on the quality of healthcare, patient safety, and the satisfaction of patients and medical professionals [Al Shamsi H et al., 2020].

Cultural differences pose a considerable challenge, even for experienced communicators, in accurately grasping and interpreting the nuances of a patient's words [Taylan C, Weber L, 2023]. For example, ethnic differences may create barrier to effective communication. True cultural competence begins with a sense of cultural curiosity, fostered through proactive questioning, attentive listening, and a readiness to use other help if needed [Sisk B, Mack J, 2018]. Patients who have communication impairments (e.g. speech and/or hearing disorders) may exhibit communication

failures in health care settings, which may make them more vulnerable to and at a greater risk of medical errors [Baylor C et al., 2019].

Canzona et al.'s research emphasizes the importance of language use in discussing sexual health, as it can significantly impact the quality of these conversations [Canzona M et al., 2016]. Efforts have been made in recent years to provide recommendations on discussing sexual health in medical settings and developing communication training interventions. However, these recommendations and interventions are often based on self-reported attitudes and experiences of patients and professionals with regard to consultations [Kelder I et al., 2022]. Research suggests that without communication skills training, many graduating residents will not be able to integrate specific psychotherapy skills into the provision of mental health care. Educating medical students about mental disorders, particularly concerning communication, presents distinct challenges compared to various other clinical disciplines [Fefergrad M, Mulsant B, 2022]. During psychiatry rotations, face-to-face patient-student interactions were more limited than in other clerkships. This can be explained by two major factors: patients with psychic disorders experience antagonistic feelings toward having medical students present; and students in the context of major mental illnesses raise physical safety concerns [Iezzoni L et al., 2006]. Hence, we can assume that there are numerous barriers and unique challenges in teaching communication skills to medical students, particularly clinical rotations like sexual health and psychiatry.

Nowadays digital revolution has a profound impact on how physicians and health care delivery organizations interact with patients [Weiner J, 2012]. The integration of electronic and personal health records, biometric and telemedicine devices, and consumer-focused wireless and wired internet applications are extensively used in highly developed healthcare systems [Weiner J, 2012]. The development of telecommunication technologies resulted in their extensive use in healthcare professional-patient interaction [Brem B et al., 2021]. Due to convenience and accessibility of cellphones, many consultations are now held via telephone communication and telephone remains the most widely utilized telemedicine technology [McDaniel et al., 2021]. It can reduce doctor-patient workloads and provides access to care without inconveniences [Campbell J et al., 2014; Haleem A et al., 2021]. The importance of telephone consultation skills is growing as healthcare continues to adapt to global trends in communication technology. Research suggests that there is an urgent need for future doctors to receive

specialized training in telephone communication skills as it involves a lot of nuances that are different from that of face-to-face interaction [Vaona A et al., 2017; Brem B et al., 2021].

To address these challenges effectively, it is essential to consider these when designing a curriculum which will help to provide training on communication to medical students.

Teaching, learning and assessment of communication skills in medical education

The approach to teaching communication is a topic of considerable debate [Perron J et al., 2015]. Many medical educators agree that effective communication skills are not inherent and can be taught through deliberate, systematic, and experiential training [Kurtz S, 2002; Choudhary A, Gupta V, 2015; Kumar R et al., 2021]. There are didactic and interactive methods of teaching. Role-play, real conversation with patients, videos on simulated clinical situations, small group discussion, bedside teaching, standardized patient encounters are among the methods of teaching communication skills [Berkhof M et al., 2011; Taveira-Gomes I et al., 2016; Baykov A, Shaghatyan T, 2022].

In medical education, there are two widely used and effective methods for teaching communication skills to students: standardized patient interactions and volunteer outpatient interactions. Standardized patients are actors trained to portray patients realistically, simulating clinical scenarios. These approaches enable medical students to gather thorough medical history, physical examination techniques, provide patient instructions such as demonstrating inhaler techniques, and breaking bad news using a patient-centered approach [Berkhof M et al., 2011; Taveira-Gomes I et al., 2016]. Research suggests that standardized patients are more useful for the pre-clinical years, especially for intimate examinations and providing instructions regarding physical examinations [Adnan A, 2022]. They offer students a safe environment to make mistakes and learn from them. Standardized patients are especially useful for cultural competence training [Walkowska A et al., 2023]. Even for students who are clinically inexperienced and have limited theoretical knowledge, this method can be used early during undergraduate studies and can be combined with more advanced teaching and learning methods [Siemerks J et al., 2023].

Volunteer outpatients are real patients who voluntarily engage in educational sessions. They are better utilized during clinical years to incorporate more medical aspects, such as making a differential diagnosis and managing illness. With additional training in procedural techniques,

volunteer outpatients prepare students to become more empathetic doctors in the future [Adnan A, 2022].

The most suitable and effective time to learn communication skills is still a matter of debate, with some authors stating that a longitudinal design throughout the curriculum including and incorporating formal communication skill teaching sessions during clinical rotations could be more effective [Rosenbaum M, 2017; Tan X et al., 2021]. Students believe that it is important to learn communication strategies throughout the medical course by integrating them into clinical practice [Taveira-Gomes I et al., 2016]. Bloom's taxonomy and Miller's pyramid learning domains have been suggested for designing formal curricula for communication skill teaching [Brown R, Bylund C, 2008; Tan X et al., 2021; Novais F et al., 2022; Adnan A, 2022]. In its turn, Kolb's experiential learning cycle focuses on the learner's personal prospective experience and it includes a four stage learning process that forms the full cycle: "...having an experience ("concrete experience"), reflecting on the experience ("reflective observation"), learning from the experience ("abstract conceptualization" and trying out what you have learned ("active experimentation")) [Kolb D, 1984; Herzog T et al., 2019; Wijnen-Meijer M et al., 2022]. It allows students to apply knowledge in hand-on experience. It encourages active participation, critical thinking, problem solving and communication skills [Kolb D, 1984]. Combined with traditional teaching methods it can yield better results in developing communication skills among medical students.

Objective Structured Clinical Examination is a commonly used assessment model developed by Harden in 1975 and adopted by medical schools to assess medical students' clinical skills and competencies in undergraduate medical education [Piumatti G et al., 2021]. The model extensively uses standardized patients. In Objective Structured Clinical Examination, students engage with standardized patients across a spectrum of clinical situations, developing their communication skills and receiving feedback. Hence, Objective Structured Clinical Examination is becoming an integral part of medical education curricula. It is commonly used to assess medical students' communication skills. Despite reliable Objective Structured Clinical Examination stations, studies show low reliability across different cases, indicating that communication skills are highly specific to the context in which they are tested [Cömert M et al., 2016].

The modern, well known medical licensure Medical Doctors graduates' exam (United States Medical Licensing Examination) incorporates clinical skills testing with the use of Objective Structured

Clinical Examination [Cömert M *et al.*, 2016; Scott S *et al.*, 2019]. It is a three-step examination that assesses a physician's ability to apply knowledge, concepts, and principles essential in health and disease, forming the basis of safe and effective patient care. In step two, students' abilities in patient-centered communication are evaluated [Fatima R *et al.*, 2021]. This evaluation occurs through standardized patient interactions, where communication skills and interpersonal abilities are assessed. Students are observed in various aspects of patient-centered communication, including fostering relationships, gathering and providing information, aiding in decision-making, and addressing patient emotions.

The communication skills in medical education are viewed as essential by international accreditation agencies, prompting their assessment among medical students and integration into curricula. This emphasis extends to licensure examinations like the United States Medical Licensing Examination, where communication abilities are evaluated to ensure effective patient-centered care.

The standards and requirements for communication skills in medical education

The importance of communication and interpersonal skills in medical education is underscored within educational standards and highly valued by international accreditation agencies and organizations, reflecting their recognition as crucial competencies for medical graduates and key components of medical practice [LCME, 2008; Elley C *et al.*, 2012; WFME, 2020]. According to the General Medical Council and the World Federation for Medical Education communication and interpersonal skills are among the essential competencies to be taught in medical programs [GMC, 2009; WFME, 2015; ACGME, 2024]. The ability to communicate is a part of professionalism, and apart from medical knowledge and the ability to provide good patient care, physicians need communication skills in many aspects of their practice yet it is often neglected [ACGME, 2024].

In the Republic of Armenia, medical professions are regulated by a number of laws, regulations, and instruments. Legislation on higher and postgraduate education adopted in 4.12.2004 [Law R, 2004] is still in force overarching legal framework for regulation, that underlines special regulated status for medical professions, is under continuous review. One of the instruments for regulation is a list of specialties approved by the government of the Republic of Armenia [DGRA, 2014]. The graduate of the continuing and integrated MD program is awarded the "MD Physician" qualification.

Another instrument for Education System in gener-

al is the Armenian National Qualifications Framework [Karakhanyan S *et al.*, 2017]. Medical professions (i.e. Medical Doctors) are covered by Levels 6 and 7. Presently, in Armenia, one-step MD Integrated educational programs are implemented. These programs are integrated Bachelor's (Level 6) and Master's (Level 7) Educational level programs with a duration of 6 years, thus encompassing both the competencies described for Level 6 and 7 Level in the National Qualifications Framework. Level 6 outlines communication competency, information communication technologies, and work with data; ability to present and explain information to professional and non-professional societies. For Level 7 communication skills outline as follows: skills to present and explain his/her own conclusions, appropriate propositions and, results of investigation [Karakhanyan S *et al.*, 2017].

The next important regulatory instrument is the Sectoral Qualifications Framework for "Medicine" in the Republic of Armenia. It covers "General Medicine", "General Medicine in Military Forces", and "Stomatology" specialties [MSQF, 2022]. Section "Knowledge and Competency" outlines communication skills as one of the key competencies required for graduates. It writes: "Demonstrate effective communication skills with patients, colleagues and other coworkers and provide consultation and information and other facts, problems related to health care among public and offer solutions". ... "Can collect, process, analyze, evaluate interpret, and present relevant data in order to solve profession related complex problems using up to date specialized computer program in case of need" [MSQF, 2022]. These skills are not only deemed essential competencies for medical students but are also recognized as key components of medical practice. In Armenian Sectoral Qualifications Framework for "Medicine", communication skills accounts for only one section out of five [MSQF, 2022].

MD Program Description is a main institutional and program level document that thoroughly depicts intended learning outcomes on communication skills. Out of the twelve program learning outcomes in Yerevan State Medical University YSMU MD academic program only four partly include communication skills.

This acknowledgment prompts the assessment of medical students on communication skills, as it is clearly reflected both in YSMU MD Program Description and Sectoral Qualifications Framework for "Medicine" in the Republic of Armenia. The presence of one state medical university and number of non-state universities providing medical education in the Republic of Armenia led to unnecessary diversity of graduates' competences lists. There is an obvious need of more precise

harmonization and regulation, such as, an additional supra-institutional regulation instrument which describes a detailed list of essential skills and competencies for undergraduate medical professionals.

Communication frameworks and models in medicine

With a better comprehension of the significance of communication in medicine, various communication models have developed for consultations, ranging from basic to more complex ones. Notable among these are the Kalamazoo I Consensus Statement, the SEGUE Framework (Set the stage, elicit information, give information, understand the patient's perspective, and end the encounter), the Calgary-Cambridge Observation Guide for teaching, learning and communication skills [Makoul G, 2001b; Rider E et al., 2006; Brown R, Bylund C, 2008].

The Kalamazoo I Consensus Statement is a foundational document in the field of health professions education, particularly focusing on the development and evaluation of communication skills. It outlines its importance and key principles, and strategies for teaching, assessing, and integrating communication skills into medical curricula [Makoul G, 2001a; Joyce B et al. 2010]. The Kalamazoo I Consensus Statement brought together educators, researchers, and practitioners in the field of healthcare communication. The statement identifies seven essential elements in physician-patient communication. These elements include building the doctor-patient relationship, opening discussions, gathering information, understanding the patient's perspective, sharing information, reaching agreement on problems and plans, and providing closure.

Communication for patient-centered care allows patients to express effectively their full set of concerns. It helps to maintain a personal connection using appropriate verbal and nonverbal techniques, gathering information by asking both open-ended and closed-ended questions and structuring, clarifying, and summarizing the information provided. It helps to understand the patient's perspective by exploring contextual factors and acknowledging their ideas, feelings, and values [Roter D et al., 2006]. The Consensus Statement supports sharing information in understandable language, encouraging questions, and checking for understanding. It helps to reach agreement on problems and plans by involving the patient in decision-making and identifying resources and supports. It supports closure by summarizing agreements and discussing follow-up plans. The Consensus Statement is a coherent framework in teaching and assessing communication skills.

The SEGUE Framework (Set the stage, elicit information, give information, understand the patient's perspective, and end the encounter) is a checklist designed by Makoul to facilitate the teaching and assessment of critical communication tasks. This is a research-based checklist that is designed to facilitate and assess communication skills in medical learners. It is widely acceptable; it employs yes/no questions. It targets specific communication tasks and whether they were accomplished during a medical encounter [Makoul G, 2001b]. The SEGUE framework comprises twenty-five items categorized into five key content areas: setting the stage; eliciting information; giving information; understanding the patient's perspective; and concluding the encounter. Of these, seventeen items pertain to content, specifying topics to be addressed or behaviors to be demonstrated during the interaction. Each content item is marked "YES" if addressed at least once, and "NO" if not addressed at all. The remaining eight items focus on communication behaviors to be consistently maintained throughout the encounter. Process-oriented items are marked "NO" if the behavior is not observed during the interaction.

The Calgary-Cambridge Model is a structured framework developed by Kurtz and Silverman to enhance communication skills in healthcare settings [Kurtz S, Silverman J, 1996]. It consists of a sequential five-step process: initiating the session, gathering information, physical examination, explanation and planning, and closing the session. Unlike traditional approaches, this model integrates both verbal communication and physical examination, emphasizing the interdependence of information gathering and communication. Despite the recognized impact of physicians' interpersonal and communication skills on patient care and healthcare outcomes, communication training remains lacking in medical curricula [Ranjan P et al., 2015]. The Calgary-Cambridge Referenced Observation Guides which provide a detailed framework for communication skill education, education offers a structured approach to patient-physician interactions. Integrating communication skills with other clinical skills is challenging in communication, especially in real-life scenarios where the models can help develop those skills as the model outlines teaching communication on both interview content and the process of communication. Thereby it integrates traditional clinical history taking methods with effective communication skill [Kurtz S et al., 2003]. The model has been extensively translated and employed for teaching communication skills within specialized settings, both at undergraduate and postgraduate education levels [Burt J et al., 2014]. Calgary-Cambridge model has

been used in the US, Canada, and Europe to teach at undergraduate and postgraduate levels [Ammen-torp J et al., 2021]. Several studies have found the effectiveness and efficiency of the use of the model for training health professionals [Ammen-torp J et al., 2021; Baniaghil A et al., 2022; Schwalbe D et al., 2024]. The MAAS Global (Maastricht History-taking and Advice Scoring List) is commonly used instrument in under- and post-graduate medical education to assess medical communication and clinical skills (it has since been revised into MAAS 2.0). The revision was made considering and aligning Calgary-Cambridge model [Stamer T et al., 2023].

A study shows that implementing communication training based on the Calgary-Cambridge guide for General Practitioners was effective. Another study shows that in primary care setting doctors who had been enrolled in communication training for General Practitioners based on Calgary-Cambridge guide later improved hypertension outcomes among patients with uncontrolled blood pressures [Zou C et al., 2024].

Each model includes clinical data gathering, rapport building and counseling about treatment, however Calgary-Cambridge model has been cited more and stands out.

Obstacles faced in teaching, learning and assessment of communication skills

The experts highlight the importance of communication skills in medical practice and the challenges faced in effectively teaching and integrating them into medical education [Choudhary A, Gupta V, 2015]. As we mentioned earlier, one of the reasons that communication problems might occur is poor communication skills, which is believed can be taught to medical students to increase clinical competence. It is a backbone over which lot of areas of patient care rests, including: first contact with patient, his interviews, counseling the patient, explaining treatment methods, its complications and advising follow-up.

While medical curricula traditionally include teaching communication skills, substantial difficulties still exist in comprehensive medical communication training programs. YSMU MD curriculum includes modules grouped in social and humanitarian modules with intended module learning outcomes ensuring good professional communication skills. But difficulties still exist in comprehensive medical communication training programs. Students and residents often try to learn communication from their teachers and through their personal experiences. Although learners perceive they are watching their teachers model patient care in “real” world, they instead often see problem solving and the thinking that

leads to diagnoses [Kurtz S, 2002]. Another observed problem is that unfortunately; students are not able to get feedback on their own communication skills from real patient. Patients on the other hand refuse to be interviewed by a student during bedside teaching [Baykov A, Shaghatyan T, 2022].

Despite the efforts of regulatory bodies, curriculum developers, and medical educators, challenges persist in comprehensive communication training programs [GMSERYSMU, 2023]. However, institutional efforts to integrate communication skills teaching and assessment methodologies into medical education curricula and the utilization of modern technologies show promise in overcoming these challenges. Driven by the accreditation bodies standards since 2023-2024 academic year, YSMU introduced the elective communication skills course as part of the new modularized program. Given the importance of communication in medical education and highlighting the need for formal training and assessment, it is recommended to consider communication skills courses as mandatory.

Suggestions for overcoming challenges

Medical educators and health care providers are putting much effort to improve communication skills in their education process, and this has become cross-cultural phenomenon not only in the United States, United Kingdom, Spain, Canada, Australia, but also in Armenia, and elsewhere. As one of the solution for this admission criteria for Medicine degrees offered by international universities normally require above minimum language proficiency exam results. Additional institutional admission requirements (e.g. oral language exams or interviews) can be set. Institutional efforts should focus on structural incorporation of medical faculty-led communication skills elective and mandatory courses into a medical curriculum, considering vertical and horizontal alignment methodology [Karakhanyan S et al., 2017].

Higher medical education field of the Republic of Armenia needs additional harmonization and regulation with the implementation of supra-institutional additional instrument describing detailed list of essential skills and competences for undergraduate medical professionals (“MD Physician” qualification holders). Development and implementation of State licensure examination for medical graduates (like United States Medical Licensing Examination) in Armenia could be a promising solution.

The integration of technologies and simulation labs in medical curricula can enhance training effectiveness by pursuing communication excellence. Based on this literature review, the Calgary-Cam-

bridge Model is highly effective framework for developing communication skills. It fosters improved dialogue between doctors and patients. And it can be used effectively for training medical students, enabling the development of essential communication skills in future physicians. Considering the widespread use of cellphones in doctors' daily interactions with patients, training in telephone communication nuances should be included. This could be implemented by using Telephone Conversations Calgary-Cambridge guide for healthcare staff developed by The National Healthcare Communication Programme (Ireland) [TCCCG, 2024].

Implementation of student assessment checklists, patient surveys, feedback forms, or structured interviews to gather real and standardized patients' feedback on student communication performance could be a part of multicomponent assessment system.

Limitations of the study

The review of the literature underscores key findings concerning the importance of communication skills, existing barriers, teaching methodologies, assessment techniques, essential frameworks, and

suggestions for overcoming obstacles. This study scrutinizes communication skills in medical education, with potential limitations to acknowledge. The research does not include written communication, which leaves the room for future study.

CONCLUSION

Integrating communication skills training into medical curricula is imperative to adequately equip future physicians with necessary clinical skills. Formalization of communication skills teaching, learning, and especially assessment with the implementation of structured frameworks (e.g. The Calgary-Cambridge Model in Armenian Higher Medical Education System) will improve medical graduates' communication skills. Implementing a supra-institutional additional regulation instrument describing detailed list of essential skills and competences for undergraduate medical professionals and centralized State licensure examination for medical graduates (similar to United States Medical Licensing Examination) in Armenia could be a promising solution.

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