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Engaging Pre-Med Students in Field-Related Dialogue: Best Practices for a Dialogic Approach to a Health-Specific Oral Communication Course

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Abstract: Using a dialogic framework as the backdrop to course curriculum, I developed an Oral Communication course for pre-med students with the goal to enhance students' public speaking skills while also incorporating health communication and applied communication research and activities to create opportunities for engagement. I propose best practices for teaching pre-med oral communication by deconstructing "bedside manner," emphasizing a dialogic, audience-centered approach to communication, illustrating the praxis of genuine communication, creating a supportive climate through nonverbal and small group communication tenets, and creating a space to practice genuine communication. Using this approach, the layperson understanding of "bedside manner" becomes an intersection of these areas to better understand the complexities of physician-patient communication.

Introduction

In partnership with a Medicine and Biosciences University (MBU), the University recently developed an accelerated undergraduate pre-med program. Students that successfully complete this program are automatically admitted into the MBU medical school. One distinct goal of this new program was to tailor general education classes to address the needs of pre-med students through specialized curriculum. Faculty teaching general education courses in this program, such as oral communication, English

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composition and literature, and modern languages were granted the freedom to create new, accelerated content and materials designed to challenge advanced pre-med students and enhance content-area knowledge to prepare them for their future pre-med courses and careers. As one of the first faculty members to teach a course for the program, I created a health-specific oral communication course that would transcend the basic tenets of oral communication.

One of the most prevalent obstacles in developing this course was dismantling preconceived notions of what constitutes communication between a patient and a physician and the conception of communication as an objective to be obtained rather than a skill to be developed. These preconceptions operate under an assumption that patient–physician communication consists primarily of "bedside manner." Bedside manner is accomplished when doctors convey humanistic, compassionate, empathetic, and supportive care (Silverman, 2012; Weissmann et al., 2006).

My objective was to introduce communication as a complex process involving more than bedside manner skills. This is intended to reverse the trend of students losing "patient-centeredness" through increased exposure to patients during their medical training (Wilcox et al., 2017). Also, little is known about how humanistic behaviors and attitudes are being taught in clinical settings (Weissmann et al., 2006). Course learning objectives included: critically evaluating public messages using critical listening skills; identifying and developing skills to manage communication apprehension; developing skills as an ethical speaker; and demonstrating the effective use of verbal and nonverbal elements of communication.

In this essay, I first describe the dialogic framework informing the course. I then illustrate how I expanded the basic tenets of speech communication to emphasize an audience-centered approach and explicate the praxis of genuine communication. Finally, I conclude with practical applications and activity examples to improve students' communication skills in their future careers.

Dialogic Communication as a Framework

To confront the bedside manner misconception, I incorporated communication curriculum that addresses issues surrounding patient rapport (e.g., listening skills, nonverbal communication, and the patient as a diagnosis rather than a person conundrum). Thus, this course focused on a patient-centered approach to oral communication aimed at mitigating negative patient–physician communication behaviors and encouraging dialogue.

The course focused on the audience-centered principles of dialogical communication as operationalized in the public relations field, which I used to address and emphasize the complicated nature of patient–physician communication. Dialogic perspectives offer an approach to ethical communication processes, as the concept of dialogue is more of a stance, orientation, or quality of the communication, rather than a particular format or method (Johannesen et al., 2008, p. 54). Dialogue as situated in public relations research bridges audience- or public-centered approaches while also embracing a dialogic model of communication. As Taylor and Kent (2014) noted, dialogue "says that organizations should engage with stakeholders and publics to make things happen, to help make better decisions, to keep citizens informed, and to strengthen organizations and society" (pp. 387–388).

This dialogical perspective emphasizes reciprocity and mutuality, as well as ethics, responsibility, and community (Keaten & Soukup, 2009, pp. 170–171). Illustrated by this mutual equality, inclusion, and

with both parties having genuine concern for one another (Botan, 1997, pp. 190–191), the dialogic communication model provides a more humanistic, communication- and relationship-centered and ethical approach to public relations (p. 196). Characteristics of a dialogical approach include authenticity, inclusion, confirmation, presentness, a spirit of mutual equality, and a supportive climate (Johannesen et al., 2008, pp. 55–56). Dialogue can mitigate power relationships through valuing individual dignity and working to involve participants in the decision-making process (Taylor & Kent, 2014, p. 388).

In the context of patient–physician communication, engaging multiple stakeholders involved in the process of "health care" must transcend the corporate notions of the medical industry and, rather, highlight the relationships involved in patient–physician communication (Lim & Greenwood, 2017). From a medical field perspective, Ranjan et al. (2015) highlighted the importance of communication in cultivating a dialogic relationship between themselves and patients to better understand patient issues, mitigate frustration during difficult encounters, and decrease job stress while increasing job satisfaction (p. 1).

Applying a public relations dialogic approach to this course foregrounds the communicative and relational aspects of the patient–physician dynamic. I used this dialogical approach as a method of breaking down preconceptions of bedside manner, emphasizing the importance of dialogue, and creating opportunities for supportive, genuine patient–physician interactions. I developed course materials with the overarching goal of enhancing students' public speaking skills while also incorporating health communication and applied communication research and activities to create opportunities for engagement. I introduced dialogic-centered key concepts from nonverbal, small group, health, and oral communication studies. In doing so, I argue that effective bedside manner sits at an intersection of these areas. I propose the following best practices based on a reflexive process of implementing, reflecting on, and revising the course throughout the term. In doing so, I hope to provide a starting point for teacher–scholars to adapt oral communication courses not only for pre-med students but other disciplines as well.

Best Practice #1: Deconstruct Bedside Manner by Applying a Dialogic Approach to Communication

One of the course goals was to help students realize the significance of communication in a physician's bedside manner. By approaching bedside manner from a communicative perspective, I encouraged students to reflect and think critically about the interaction to facilitate long-term learning.

I applied dialogic communication principles to provide opportunities for students to better understand the complexities of the patient–physician interaction and to better account for the mechanisms that may affect such an interaction. I organized the course readings, discussions, and activities to consider important issues such as nonverbal communication during an interaction, the use of technology, previous interactions with the patient and other key stakeholders such as office and medical staff, communication while under stress, and how their own perceptions of a patient may affect the communication occasion.

For one in-class discussion, students reflected on the significance of their perceptions. I asked students to devise a one-sentence explanation of a specific health-related quote and propose two examples of how the quote relates to their future career. To debrief this activity, I asked students to reflect on their interpretation of the quote and discuss how their own understanding of the quote compared to

their classmates' interpretations. Because of the various backgrounds and experiences of the first-year students, interpretations were divergent, which yielded a concrete yet simplistic illustration of how our perceptions can differ greatly.

Furthermore, throughout the course, students posed questions with the expectation of finding "silver bullet" answers to potential patient–physician communication issues and scenarios. The most rewarding aspect of this class was witnessing students' continual improvement in considering potential communication issues from multiple perspectives. As we proceeded together through the course, students began moving away from standard solution-based inquiries and toward a better understanding of the complexities of human communication.

Best Practice #2: Maintain Basic Speech Communication/Oral Communication Tenets While Emphasizing a Dialogic, Audience-Centered Approach to Communication

The overarching goal of the course was to improve the students' public speaking skills and emphasize the praxis of dialogue. I used dialogue as an attempt to improve the critical interactions the students, as future physicians, will have with their patients.

Thus, the major course assignments were an informative speech and a persuasive speech, each of them underscoring a connection to the medical field. The goal of the informative speech was to simplify a complex medical issue or procedure and inform their audience, either layperson or expert, about a specific issue. For the persuasive speech, the objective was to consider the importance of understanding their audience and the challenges of adjusting their communication to maximize effectiveness. For each assigned speech, students were asked to consider the potential power dynamic inherent in the patient–physician relationship and adjust their communicative opportunity in the form of a speech to their audience. These assignments offered dialogic opportunities to explore students' own understandings of why they are pursuing a career in the medical field while also enhancing their understanding and experience in engaging in dialogic communication by considering their stakeholder, or audience.

Throughout the semester, students expanded on speech communication audience-centered approaches while also attending to humanistic, compassionate, and empathetic dialogic communication processes. For example, in role-playing and discussion activities, students reflected on space and proximity by kneeling to make eye contact with what would be a child patient and changed the language in speeches to avoid jargon and show care. Finally, even the student speech topics evolved by the end of the semester to address health-related communication issues, such as "whitecoat syndrome," a condition in which patients may be affected by nervousness and apprehension when interacting with health-care workers.

Best Practice #3: Illustrate the Praxis of Genuine Communication

Another course goal was to encourage students to consider difficult communication phenomena they may face in their future careers. In lecture, I discussed the significance of praxis and the intersection of skills, theory, and applying knowledge to emphasize a dialogic approach to the patient–physician relationship. Students also explored the praxis of genuine communication through assigned readings that discussed genuine communication in physicians' communication styles, end-of-life communication, and the communication of hope. I assigned Mazzi et al.'s (2015) article which focused

on what people appreciate in physicians' communication, concluding that demonstrating competency and self-confidence was highly appreciated (p. 1224) and noting that "affective communication is highly valued by nearly everybody, as long as it stays at a professional level and is perceived as genuine" (p. 1224).

I drew from hospice and cancer health communication research to examine the praxis of genuine communication for our end-of-life section of the course. For these communication discussions, research by Candrian et al. (2017) best fit the dialogic approach framework to this course because of its emphasis on stakeholder-specific perceptions and its operationalization of Street's (2003) ecology theory of patient-centered communication which "focuses on the complex interplay between individual, relational, community, and societal influences on interactions around health" (Street, 2003, as cited in Candrian et al., 2017, p. 3). Student discussions focused on how political, social, and cultural contexts contribute to the complexities of the interaction between hospice nurses and patients and families. This emphasizes the need for future physicians to consider how hospice admission interaction is entrenched within various contexts, affecting how individuals make these decisions.

An additional topic of interest in the end-of-life curriculum is discourse surrounding "hope," which further complicates the patient–physician communicative interaction. Communicating hope is complex, especially in the context of dealing with a terminal illness (Koening Kellas et al., 2017, p. 1). For this topic, students discussed the following questions with a classmate: What are the advantages and disadvantages of communicating hope to patients? When do you believe it is appropriate or inappropriate? What makes communicating hope to patients complex? Who might be affected by communication of hope and when? After debriefing the discussion questions as a class, we reviewed the communication of hope based on the Koening Kellas et al. (2017) article. The discussions and engagement with the praxis curriculum resources resulted in students often sharing their own experiences with physicians, including in the end-of-life context. Reflecting on students' responses to this portion of the course, I recommend incorporating these more difficult conversations in midsemester to avoid ending on a particularly emotionally challenging topic.

Best Practice #4: Create a Supportive Climate Through Nonverbal and Small Group Communication Tenets

Another course goal was to incorporate nonverbal and small group concepts that help foster a supportive climate for patient–physician communication. To examine the intricacies of the patient–physician interaction, I applied nonverbal and small group communication concepts from *Nonverbal Communication in Human Interaction* (Knapp et al., 2013) and *Communication in Small Groups: Principles and Practices* (Beebe & Masterson, 2014).

Nonverbal lecture material and activities incorporated key topics such as: the importance of physicians' nonverbal communication (Mast, 2007), GroupThink (Knapp et al., 2013), effects of technology on rapport (Booth et al., 2004), active listening and expression of emotions (Roter et al., 2006), and perceptual research (Loeb et al., 2012). Two important concepts discussed in class were active listening and expressiveness in patient–physician interactions. Active listening skills are essential to dialogic communication. These skills include "listening, empathy, being able to contextualize issues within local, national and international frameworks, [and] being able to identify common ground between parties" (Kent & Taylor, 2002, p. 31). Another nonverbal communication issue we explored was expressiveness

in patient–physician interactions. Mast (2007) conceptualized expressiveness nonverbals as "less time reading medical chart, more forward lean, more nodding, more gestures, closer interpersonal distance, and more gazing" (p. 316).

To introduce the Booth et al. (2004) article on the effect of computer use on patient–physician rapport, students paired off to discuss the following questions: Why is interpersonal communication and listening important? How do you offer rapport with patients while spending time engaging with the computer? To practice engaging the concepts from the article, students partnered with a classmate to perform and simulate the three types of general practitioner behaviors, which include controlling, responsive/opportunistic, and ignoring. These simulations offered students an opportunity to speak in front of the classroom, while also reflecting on strategies to manage transitions between the patient and computer screen or technology. I debriefed this activity by returning to the article and its conclusion that when confronting the difficulties of multitasking during patient–physician interactions the soundest approach is to try to ensure that the physician will not be required to attend to the patient at the same time they are engaged with technology, and vice versa (Booth et al., 2004, p. 82).

Best Practice #5: Create a Space to Practice Genuine Communication

Another course goal was to offer students a space to apply course content through practice and engagement with their classmates. I incorporated communicative activities that nudged students beyond their comfort zones within a safe space to perform and refine these key genuine communication processes.

I found one activity to be particularly effective in emphasizing the importance of a dialogic model of communication related to nonverbal communication. Adapted from "Trainers' Tips: Active Listening Exercises" (Norman, 2018), this activity involved active listening and allowed students the opportunity to acknowledge how often they are distracted during conversations due to internal distractions.

To begin, the class was divided into two groups, Group 1 and Group 2. The students in Group 1 went into the hallway where I asked them to think of a good story or experience that had occurred over the holiday break. Members of Group 1 partnered up with a member of Group 2 to discuss their story in the classroom. I instructed students in Group 2 to raise their hand for 5 seconds, without explaining their actions to their partner, each time they wanted to ask a question, their mind started to wander, or they were thinking of a reply. During the activity, Group 2 students were intermittingly raising their hands, creating laughter, confusion, and frustration for their partner because they could not explain why they were raising their hand.

After a period, Group 2 students were able to discuss why they were raising their hand, and Group 1 students told their stories again without the physical disruption that represents inner disruptions that interfere with active listening. Students compared the two conversations that demonstrate active listening and feeling listened to in communication. This activity was then discussed in terms of improving listening when communicating with a patient, which lead into lecture and discussion on the use of technology during a patient interaction and its effect on rapport (Booth et al., 2004), and the importance of expression of emotions during patient–physician communication (Roter et al., 2006).

Conclusion

My intent in adapting this oral communication course to focus on pre-med students was to enhance the students' understanding of communication as it may affect their future careers and interactions with patients. One limitation of this best practices study is that it does not measure affective, cognitive, and behavioral learning objectives. Future research is needed to better understand the short-term and long-term student learning process through nuanced formative and summative assessments.

This approach demonstrates one method for tailoring a core communication course for a specific discipline. I argue that this type of cross-discipline course and curriculum has the potential for reinvigorating a core class by tailoring it to other areas of study, such as the medical fields, engineering, design, and so forth. This has the potential to encourage collaboration between university schools, departments, and colleagues to better understand communication challenges students may encounter in their professions.

Improving bedside manner is not just for students in the classroom, as it can be an important part of professional training and development in the medical field. To engage with practicing medical professionals, communication teachers and scholars can create workshops, certificates, presentations, and other opportunities to highlight the relationships involved in patient–physician communication and present practical strategies to improve the patient–physician stakeholder relationship by applying key concepts of dialogic communication theory. This could provide medical professionals an opportunity for professional development by learning, among other things, how physician expressiveness, technology use during patient visits, and nonverbal communication—such as displaying empathy—affect patient–physician rapport.

Developing accelerated content and materials designed to challenge advanced pre-med students and enhance content-area knowledge expanded upon the general education course learning objectives to better prepare them for their future pre-med courses and careers. Feedback from students revealed their appreciation for this interdisciplinary approach to the general education communication curriculum. For instance, one student stated that "we would benefit in our career paths" by taking the course, while another student expressed that the course "made it a priority that we understand how communication plays an important role in the medical field" and incorporated materials that "really grasp our attention." This type of feedback gives me hope that using dialogue as a framework for pre-med communication courses may help these future physicians provide more effective care and result in healthier, happier patients in the long run.

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