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Clinical Communication Competency in Medical Education: Feasibility in Ecuador

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A R T I C L E I N F O

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A B S T R A C T

Clinical communication is a core competency in modern medical education due to its impact on diagnostic accuracy, therapeutic adherence, patient satisfaction, and the humanization of healthcare. This article analyzes international trends in communication skills training and evaluates their feasibility in Ecuadorian medical curricula. A reflective analysis was conducted using experiential learning, social constructivism, the biopsychosocial model, and principles of bioethics and interculturality. A structured search of peer reviewed literature (2015–2025) identified global strategies such as simulation, role play, standardized patients, and OSCE based assessment. Evidence shows that communication skills are learnable and assessable, and that faculty role modeling is essential. Ecuadorian studies reveal deficiencies in empathy, listening, and relational skills among physicians, highlighting the need for curricular reform. Findings indicate that implementing longitudinal, competency based communication training in Ecuador is feasible and necessary to strengthen the physician–patient relationship and improve healthcare quality

INTRODUCTION

Communication is widely recognized as an essential competency in medical and health sciences education because it constitutes the foundation of the clinical process. Through effective communication, clinicians obtain accurate diagnostic information during the patient interview; moreover, they build relationships of trust and empathy that enhance treatment adherence, reduce the likelihood of errors, and ultimately influence patient satisfaction and measurable health outcomes based on key indicators (Reyes et al., 2018).

Clinical communication is understood as an intentional, structured, and interactive process through which health professionals, patients, and their family or social environment exchange information, emotions, perceptions, beliefs, and values within the context of individual or collective healthcare. This process fulfills diagnostic, therapeutic, educational, preventive, and supportive functions, and is characterized by its bidirectional, dynamic nature, adapted to the biopsychosocial and cultural framework of the individuals involved (Stellyes et al., 2020).

Over recent decades, clinical communication has re-emerged as a core competency in undergraduate and postgraduate medical training, increasingly regarded as a transversal axis that sustains healthcare delivery in the twenty-first century (González-Blázquez et al., 2024). The rapid expansion of new technologies, social changes driven by digitalization, and the growing demand for a more humanistic, patient-centered approach have reshaped how clinical communication is conceptualized, taught, and assessed (Maldonado & Pailaquilén, 2021). Understanding its scope, dimensions, relevance within the physician–patient relationship, distinctions from other health-related communication domains, and the theoretical models that support it is essential for educators, students, clinicians, and healthcare administrators alike (Guaresti et al., 2023).

Effective clinical communication forms the basis of a high-quality physician–patient relationship and functions as a therapeutic tool in its own right. It enhances diagnostic accuracy and decision-making, promotes treatment adherence and self-care, reduces conflict, and increases satisfaction for both parties by fostering an empathetic bond. Furthermore, effective communication contributes to the humanization of medicine, enabling clinicians to understand the patient as a "person experiencing illness," rather than merely a "carrier of disease," and certainly not as a "client." Consequently, integrating communication skills into medical curricula represents a critical challenge for preparing future health professionals.

International experiences and implemented programs highlight the importance of establishing educational strategies that ensure the systematic development of clinical communication as an essential competency. Such strategies equip health professionals with the tools needed to address the challenges of clinical practice through a more humanistic, ethical, and effective approach to care.

From this perspective, a key question emerges: Can Ecuadorian medical schools implement these strategies to ensure high-quality training that guarantees clinical communication as a core competency of future health professionals? The objective of this article is to analyze international trends in the teaching and assessment of communication skills in medicine, as well as to evaluate their feasibility for implementation within the Ecuadorian curriculum.

LITERATURE REVIEW

Within medical education, clinical communication is a professional competency—observable and assessable—that must be intentionally developed beyond the everyday or spontaneous communicative abilities that future physicians may possess (Perrón et al., 2015). Both the literature and regulatory bodies emphasize that it is not an innate capacity acquired merely through clinical exposure, but rather a set of skills, attitudes, and theoretical–practical knowledge requiring systematic instruction, supervised practice, and reflective evaluation throughout medical training (Choudhary & Gupta, 2015).

METHODOLOGY

This reflective article adopts an integrative methodological approach that combines experiential and constructivist learning theories, the biopsychosocial model of healthcare, and the principles of bioethics and interculturality. These frameworks provide the conceptual basis for examining international practices in the teaching and assessment of communication skills in medical education, as well as for evaluating their feasibility within the Ecuadorian context.

A structured bibliographic search was conducted using Google Scholar. The keywords skills communication, clinical communication, medical education, habilidades comunicativas, comunicación clínica, and educación médica were used to identify relevant literature. Original peer reviewed articles published in English between 2015 and 2025 were included. Selected studies were analyzed for their conceptual contributions, methodological approaches, and potential applicability to Ecuadorian medical training.

The pedagogical analysis was informed by Kolb's experiential learning model, which emphasizes the iterative development of communication competencies through concrete experience, reflective observation, conceptualization, and active experimentation. Vygotsky's social constructivism was incorporated to highlight the role of interaction with patients, peers, and clinical tutors in fostering collaborative learning and skill acquisition. Additionally, principles of competency based education were applied to align instructional strategies with the knowledge, skills, and attitudes expected of future physicians.

These educational models were examined in conjunction with the biopsychosocial perspective, recognizing that effective clinical communication integrates biological, psychological, and social dimensions of care. Bioethical and intercultural principles were also considered essential, given their relevance to patient rights, professional conduct, and culturally responsive practice.

Through this analytical process, the authors critically assessed the feasibility of adopting global trends in communication skills training within Ecuadorian medical curricula.

RESULTS

Contemporary medical education increasingly recognizes communication as a learnable, structured, and assessable competency rather than an ancillary trait. Consequently, undergraduate programs have developed dedicated curricula with explicit objectives, content areas, methodologies, and assessment tools aligned with current cultural and technological realities.

The study by Chapues et al. (2023) illustrates this trend through a comparative analysis of interns from three Colombian universities. Their findings show that communication competencies extend beyond information transmission to include active listening, empathy, emotional regulation, and the ability to adapt discourse to the patient's cultural and educational context. Although students reported having learned communication techniques, they faced challenges in practice due to time pressure, service overload, limited feedback, and unfavorable hospital environments. A key finding was the influence of faculty and attending physicians: interns tend to replicate the communicative styles and attitudes they observe in their clinical tutors.

The proposal by Wen Lin Lo et al. (2020) addresses these challenges by integrating instructional design, educational theory, and clinical practice through Gagné's model. The nine-step sequence begins with capturing students' attention through impactful clinical cases or patient testimonies, followed by clear learning objectives, activation of prior knowledge, explicit instruction, guided learning, simulated practice with standardized patients, immediate feedback, structured assessment, and strategies for retention and transfer.

Similarly, Rasenberg et al. (2023) implemented a longitudinal training program that integrates communicative and medical competencies. Their results indicate that 91% of students felt that integrated consultations facilitated the application of communication skills in real settings, 95% valued working with realistic clinical cases, and 85% highlighted the benefit of receiving simultaneous feedback on communication and medical knowledge.

The Polish study by Borowczyk et al. (2023) used the Delphi technique to reach consensus on a comprehensive communication-skills curriculum. Expected learning outcomes included active listening, empathy, shared decision-making, teamwork, and management of complex situations. The authors recommended diverse teaching strategies such as lectures, workshops, simulations, OSCE, and mini-CEX.

In Spain and Croatia, Ferreira-Padilla et al. (2015) demonstrated that communication-skills training strengthens the physician–patient relationship and improves care quality. Experiential learning and person-centeredness emerged as essential components.

A broader study by Moezzi et al. (2024) compared communication skills among students, residents, and faculty. Their findings revealed variability across levels and reinforced the need for communication as a transversal competency throughout medical training, assessed objectively through OSCE.

Several studies reaffirm the importance of the OSCE in evaluating communication skills. Graf et al. (2020) found that empathy was the least developed skill among students, prompting curricular redesign. Agago et al. (2021) emphasized the need for educators to design and implement communication-centered strategies using standardized patients.

In Mexico, Reyes et al. (2018) reported that although physicians believed they communicated well, only about 30% demonstrated adequate listening skills and empathy, highlighting the need for structured training from undergraduate education onward.

Studies by Choudhary & Gupta (2015), Ramezani et al. (2023), and Chen et al. (2023) highlight the Calgary-Cambridge model as an effective framework for structuring medical interviews.

Collectively, the evidence underscores the need for experiential and reflective methodologies—simulation, role-play, immediate feedback, direct observation, case analysis, and critical reflection—and for integrating communication across the curriculum.

In Ecuador, several studies report persistent deficiencies in empathy and communication, reflected in high levels of patient dissatisfaction (Díaz-Narváez et al., 2021; Díaz-Narváez et al., 2025; Vélez & Castellanos, 2024; Zambrano & Serpa, 2025). Higher empathy scores were found among pediatricians, psychiatrists, and family physicians, while palliative care showed insufficient empathy.

Multiple strategies appear applicable to Ecuador: the Calgary-Cambridge guide, role-play in simulation, integrated competencies, and structured training for delivering difficult news. Simulation-based environments with prebriefing, briefing, and debriefing phases support meaningful learning.

Assessment methods such as OSCE and mini-CEX are viable for undergraduate and postgraduate education, provided communication skills are explicitly included in checklists.

Finally, communication must be reinforced throughout professional practice, especially among educators, as students learn as much from observed behavior as from formal instruction.

DISCUSSION

The results demonstrate that communication is a structured, learnable, and assessable competency requiring intentional curricular design. International evidence consistently supports active methodologies -clinical simulation, standardized patients, role-play, and structured feedback- as essential for developing communication skills that enhance empathy, listening, emotional regulation, and patient-centered care.

Several key themes emerge from the reviewed studies:

Transfer to Clinical Practice

Integrated training models, such as those described by Rasenberg et al. (2023), improve the transfer of communication skills from classroom to clinical settings, particularly when communication is taught alongside medical content.

Role-modeling

Findings from Chapues et al. (2023) and Reyes et al. (2018) highlight that students replicate the communicative behaviors of their clinical tutors. This underscores the need for continuous faculty development to prevent educational obsolescence.

Assessment Tools

OSCE and mini-CEX are validated tools for evaluating communication skills. Studies by Graf et al. (2020) and Agago et al. (2021) show that structured assessment reveals gaps—particularly in empathy—that require curricular strengthening.

Curricular Integration

Evidence supports embedding communication across multiple courses (Semiology, Internal Medicine, Pediatrics, Ethics, Public Health, Gynecology, Psychology, Surgery) rather than isolating it in a single module.

Ecuadorian Context

Local studies reveal deficiencies in empathy and listening among physicians, confirming the need for structured communication-skills training. The applicability of international methodologies is high, especially simulation-based learning and the Calgary-Cambridge model.

Longitudinal Approach

Communication must be taught progressively throughout undergraduate, postgraduate, and continuing education. This aligns with competency-based education and ensures sustained development.

Overall, the discussion supports the feasibility and urgency of implementing structured, longitudinal communication-skills training in Ecuadorian medical education. The evidence aligns with global trends and responds directly to documented deficiencies in the physician–patient relationship in Ecuador.

CONCLUSIONS AND RECOMMENDATIONS

Clinical communication is a core, complex, and dynamic competency that is indispensable for the responsible, effective, and humanistic practice of medicine. Its teaching and assessment must be longitudinal, structured, and intentionally designed.

The immediate future of clinical communication in medical education requires the consolidation of active methodologies and practical experiences—such as clinical simulation, role play, and structured feedback—along with its sustained, longitudinal integration throughout the curriculum, supported by clear objectives and continuous evaluation.

The importance of implementing these strategies in Ecuadorian medical education is undeniable, both at the undergraduate and postgraduate levels, as well as within continuing education programs for health professionals. Only through such efforts will it be possible to ensure the development of physicians capable of meeting the demands of modern medicine, strengthening the therapeutic relationship, and contributing to the humanization of healthcare.

FURTHER STUDY

Future research should explore:

1. Impact of simulation on empathy among Ecuadorian students.
2. Effectiveness of OSCE communication stations across universities.
3. Patient perceptions of physician communication in Ecuador.

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