

Across the Silos: Teaching Communication Skills in Health Professions Education

Thank you to everyone who made time to speak with us. These interviews were done for our own product research, but partway through, it became clear that what we were hearing was worth sharing back with the people who shared it. What follows is a summary of what we heard. Some of it will be familiar. Some may surprise you. We hope you find both useful.

Background

In 2025 MediaCombo received an NIH SBIR grant, with the University of Miami Miller School of Medicine and School of Nursing and Health Studies, to study whether Visual Thinking Strategies (VTS) delivered in virtual reality could teach communication skills to interprofessional groups of students. VTS is an established, facilitated discussion method that uses visual art to develop close observation, deep listening, and collaborative meaning-making skills applicable to clinical practice. Those sessions ran in our prototype virtual museum, ViTaLS: Virtual Thinking & Learning Strategies.

As an SBIR awardee, MediaCombo was invited in 2026 into an NIH I-Corps Accelerator, a program that asks small businesses to conduct 100 customer discovery interviews to find out who their customers are and what those customers need built. Because ViTaLS teaches communication skills to interprofessional healthcare student groups, we wanted to know how educators teach those skills now.

Between June and August 2026, Robin White Owen, President of MediaCombo, interviewed 124 people: institutional leaders, faculty, and educators in medical humanities, simulation, and interprofessional education. She asked each of them what they are trying to accomplish when they teach communication skills, how they know it is working, and what gets in the way. She also asked those outside medical humanities what they knew of the FRAHME report (Fundamental Role of Arts & Humanities in Medical Education), and of medical humanities more broadly. All interviews were conducted in confidence.

Who we spoke with

This report draws on 86 of those people, from 49 organizations, counting a medical school and its affiliated hospital as one. Of the rest, 14 worked at virtual reality companies rather than in education, 14 did work unrelated to this research, and ten covered ground the other interviews had already established.

Nearly three in four held a leadership title. Twenty-two led at the level of an institution or a national body: deans, vice presidents, department chairs, and the people who run education and assessment at national organizations. Forty-two directed a program, course, center, or curriculum thread inside a school. Seventeen were faculty who teach and build curriculum without a directing title, and five ran simulation or extended reality facilities.

Thirty-three of the people we interviewed lead or teach medical humanities — 24 of them in leadership roles, 9 as faculty — and five of those work in interprofessional education, simulation, or institutional leadership rather than in a humanities program.

Seven in ten came from a clinical profession — 30 physicians, 14 nurses and advanced practice nurses, 8 physical therapists, 3 paramedics, 2 pharmacists, a drama therapist, and one each from social work, athletic training, and speech-language pathology. The remaining 25 came from outside clinical practice: humanities and social science scholars, engineers and technologists, psychologists, assessment specialists, instructional designers, and a former art museum director.

At least ten of the clinicians hold arts or humanities training of their own — among them a surgeon who trained as an architect, a physician with a PhD in English, and five people who completed art museum fellowships or facilitator certification. Our notes record training only where it came up in conversation, so the real number is higher.

Most of our interviewees worked in schools of medicine, nursing, and the health professions. Smaller numbers worked in hospitals and health systems, at national organizations that set standards or fund education, and one directs an online nursing school. One worked outside the United States.

Sixteen of the 86 came from two large universities, drawn from several different schools — medicine, nursing, pharmacy, physical therapy, and university-wide centers. We did not set out to weight the sample that way; it reflects where an existing research collaboration and a chain of referrals led us.

Seventy-seven of the 86 came to us through referrals from educators we knew or who were recommended to us. Two came from the AAMC Arts & Humanities website, two from LinkedIn, and five from the International Virtual Reality Healthcare Association.

We did not ask participants to evaluate ViTaLS or compare themselves with other institutions.

What We Heard

Educators may teach different communication skills, use different terminology and methods, and measure different outcomes, yet share many of the same goals and challenges. This report describes the commonalities and differences that we found and reveals a network of common concerns and interests that can connect medical humanities, interprofessional education and simulation programs to strengthen human to human communication skills.

We describe where these communities share goals, where their vocabularies diverge, how each measures what it teaches, what shapes the place of humanities in a curriculum, how simulation and interprofessional educators are using technology, and what academic leaders told us. It closes with where the interviews suggest these communities could be useful to one another.

This report includes no participant or institution names. Counts describe how often something was raised with us; we did not always ask participants to rate importance.

Three communities with shared goals and one shared tool

Each of these communities has its own literature, its own conferences, its own funding streams, and its own vocabulary. Each teaches through a characteristic method: close encounter with art, literature, and other art forms; rehearsal under realistic conditions; structured team practice across professions.

Our interviewees named fifteen distinct accrediting and standards bodies with competency requirements, across medicine, nursing, pharmacy, physical therapy, public health, social work, and allied health.

Empathy is one of the skills we specifically asked about, and the variety of teaching methods is striking. Humanities educators pursue it through sustained looking at artwork, close reading of narrative, and other art forms. Simulation educators pursue it through encounters with standardized patients, and by putting learners inside another person's position. Interprofessional educators pursue it through direct contact with patients, caregivers and community members — people living with the conditions students will treat. One leader pursues it by selecting for it in admissions rather than teaching it later. One interprofessional leader described empathy as already embedded throughout her curriculum, and therefore not something she teaches deliberately.

Empathy also sits differently in the frameworks our interviewees cited. Among the fifteen bodies they named, only one was described as naming empathy explicitly, and that one reframes it as compassion, on the reasoning that compassion produces behavior an observer can see in the room. While everyone we spoke with agreed empathy matters, they acknowledged that it is very hard to measure.

A shared tool. Standardized patients appear in all five groups we interviewed — the only method that does. For example, simulation programs run them with

behaviorally anchored rubrics; interprofessional programs run them in team encounters; some humanities programs run them for end-of-life conversations and communication courses. The shared incumbent technology of communication education is a trained human being playing a patient.

Reflection and debriefing serve the same purpose under different names. Forty-one of the people we interviewed build in time to process an experience after it happens. What they call it, and how they structure it, differs.

Medical humanities educators call it reflection, and most build it into their teaching — reflective writing, narrative work, small groups meeting through a clinical year. It tends to be continuous rather than tied to a single event. One program has moved away from assessing through reflection, toward a mix of assignments and exams.

Simulation and interprofessional educators call it debriefing, and describe it as structured and often expected; debriefing frameworks are required in nursing accreditation. One said plainly that communication lives in the debrief. When one interprofessional office bought virtual-reality software, it co-designed the debrief alongside it. Only two medical humanities interviewees used the term “debriefing.”

The term “communication” contains many skills*

Across the fifteen accrediting bodies named by our interviewees, there are at least three broad communication goals. Some mandate communication with patients — history taking, breaking bad news, goals-of-care discussion, health-literacy-appropriate explanation. Others mandate communication within teams — structured handoff, closed-loop verification, speaking up across a hierarchy. One mandates communication with publics and audiences — conveying findings to communities and non-specialist stakeholders. A fourth is emerging in nursing standards: communication through telehealth and other remote encounters, named as its own competency.

Practitioners state the distinction clearly when asked. One interprofessional educator specified that her target is practitioner-to-practitioner, explicitly not practitioner-to-patient. A public health educator’s competencies concern communicating findings to diverse audiences, which shares almost nothing operationally with breaking bad news.

However, many of the same underlying skills serve all of these areas. Our interviewees named the skills listed in the table at the end of this document. Empathy may have appeared so often because it was one of the skills we specifically asked about.

We also heard a growing view that communication should be treated as a technical competency rather than a soft skill.

Working separately, sometimes on the same campus

Seven interviewees described an arts, humanities, or simulation program at their own institution that they were not connected to. An interprofessional education director was only slightly aware of a medical humanities master's program at the same university. Another had an arts-and-medicine program on campus and no relationship with it. A third described a co-curricular unit mounting health-art exhibitions and said plainly that the two were not connected. A fourth said museum-based teaching ran through the medical school rather than her interprofessional program, and she would like to bring it across. A fifth offered to find out what art-based work others on her campus were doing. And two medical humanities faculty had no contact with the simulation center on their own campus, and did not know whether humanities work happened there.

A few examples show the possibility of connecting the silos. One interprofessional educator with a background in theater has built museum-style exhibits, auditory-hallucination simulations, and musical theater into their teaching, and argues that arts work should be recognized as simulation. One interprofessional educator trained in visual thinking strategies through a museum faculty program and now facilitates it inside a required ethics class. One educator proposed combining museum-based looking with simulation debriefing. One simulation leader completed a narrative medicine program and ties art's ambiguity directly to patients' ambiguity, though he does not run a program.

Measurement matters to everyone, and is hard for everyone

Interprofessional education and simulation have measurement instruments. They named validated collaboration and competency instruments in routine use — pre- and post-program scales, structured clinical evaluation instruments, peer-assessment tools. Simulation programs named behaviorally anchored rubrics, validated communication frameworks, and structured debriefing protocols. Neither community regards measurement as entirely solved, and whether these instruments capture behavior or self-perception was not always clear from the interviews.

Medical humanities educators named measurement as an unsolved problem more often than other communities, and only a small number reported an instrument in routine use. We heard that existing scales do not capture what the work does; that the dose is sometimes too small to evaluate meaningfully; that the field needs outcomes beyond satisfaction; and that there is a mismatch between humanities aims and discrete measurable outcomes. As one leader explained, competency-based frameworks create tension with humanities assessment because growth in these areas is not linear. A temporary dip in demonstrated empathy, for example, may not indicate failure but increased awareness. One educator has begun building her own cross-disciplinary instrument because she could not find a suitable one.

However medical humanities interviewees also described studies they had conducted showing gains in observation, reflective capacity, tolerance of ambiguity and wellness, along with studies underway and completed work not yet published.

Empathy and tolerance of ambiguity are difficult to measure for everyone. Medical humanities educators told us this consistently, and several interprofessional educators said the same. One interprofessional director said tolerance of ambiguity, bias, and empathy are assessed only superficially, or not directly at all, so better assessment tools would help.

Other conditions shaping medical humanities

Humanities educators told us that securing a required place in the curriculum remains unresolved at many schools. Simulation and interprofessional educators did not name winning a curricular slot as a concern.

Clinical relevance is often the condition of acceptance. Many humanities educators design explicitly for it: pairing museum observation with physical-examination teaching; setting radiographic images alongside artwork; tying narrative and listening to students' first patient interviews; or running reflective groups inside the clinical year. Several described it as what earns the work credibility with clinical colleagues, and with it curricular time, and told us the body of evidence is still building.

The capacities humanities teaches are named in competency frameworks, usually in broad terms. Close observation, empathy, reflection and tolerance of ambiguity appear, but often without the observable behaviors that assessment is built on. Educators described translating their work into the nearest available competency. That can secure a place in the curriculum while obscuring what they are actually teaching: a museum session may be recorded as teaching communication when the educator believes they are developing close observation. Several told us the fit is strained. One is skeptical that empathy and the humanities map cleanly onto competencies at all, and has aligned her course to none. One said assessing tolerance of ambiguity has to begin with defining the construct. Interprofessional educators map their work to competency frameworks as a matter of course, yet one director told us that these same skills — tolerance of ambiguity, bias, empathy — are assessed only superficially, or not directly at all. Where competencies are not defined schools develop their own communications definitions and assessments.

Placement varies, and so does what puts a program at risk. Programs run as required threads, as electives, as both, and as content folded into other courses. Among the programs that ended, we heard four reasons. Student demand: one elective closed when pass/fail grading left no grade to earn and students put their time toward what helped their residency applications. Curriculum change: a

twenty-year museum-based elective was restructured out, and an eight-week course was sunset for space during an accreditation review. Program design: one educator described a museum-based interprofessional session where too few facilitators and an unsuitable format meant it did not work. Absorption, where a program ends as a named offering while the teaching continues under another label. A fifth reason, the loss of a champion, is described below. Notably, no one reported a program dropped specifically for lack of evidence, or because leadership opposed it.

Curriculum change also adds. One standalone elective was dropped for low enrollment, and its content moved into required courses where it now reaches more students than the elective did.

Every new school we spoke with built humanities in as required content. Four of the schools in our interviews opened within the past eight years, and in each one this work is required or threaded through the curriculum rather than offered as an elective.

At one, art runs through an integrated, fully flipped curriculum for empathy, in a required four-year thread whose session objectives map up to accreditation standards; an art museum is a formal partner and students hold memberships there. At another, narrative medicine is woven across four years and museum visits bookend the program, the final one often described by students as the most memorable experience of their four years. The third is striking: a three-year accelerated, tuition-free, primary-care program with twenty-four students per class still carries a required longitudinal course combining ethics, humanities and health system science. At the fourth, an engineering-based school, a four-year medical humanities stream carries social justice, an unconscious-bias simulation, and visual-space work taught with architecture faculty.

Established schools are retrofitting this work into curricula built without it. While we can't say how common the pattern is, among schools designing a curriculum now, this is evidence that humanities courses are required.

Programs depend on a champion, well after they are established. Several described needing a clinical sponsor or a dean before a course could exist, and articulating the work's value in terms leadership already uses. Others described the other end of it: a course that ends when its teacher leaves, a founding group still teaching fifteen years on because nobody replaced them, and curricula drifting back toward convention once founders move on.

Simulation and interprofessional educators also described needing sponsors, though usually for a purchase or to carry a project past a pilot.

Dose varies because the methods and their placements do. One humanities educator holds that a single short session is enough, because the method is additive and one conversation does the work. A course director running a three-year longitudinal thread wants spiraling exposure instead. One faculty member has the opposite situation: her allocation is small enough that she cannot generate the evidence that might justify more. Different methods are used at different points in a curriculum, and our interviews suggest the field has not yet had the chance to establish what dose does what.

Simulation and interprofessional programs also teach communication with a variety of methods at several points in a curriculum. The difference we heard is that their targets are more often clinical skills that can be observed and scored more easily.

Funding is about source and security. Electives and pilots rely on endowments, soft money, donor funds, grant cycles with visible cliffs, and in one case a faculty member paying for museum sessions out of her own pocket.

Simulation and interprofessional educators also run pilots on grant money and worrying about what happens when it ends. Simulation educators have to negotiate license structures; they object to per-seat pricing and feel budgetary pressures.

Location and cohort size are practical constraints. Four educators using art-museum-based programs described a group-size ceiling on museum sessions, a cohort too large for museum logistics, and a site with no museum at all.

Simulation educators also mentioned cohort size and logistics as challenges.

How interprofessional and simulation educators use technology

Our interviews showed a sharp difference in technology use. Immersive virtual reality is in routine use across most simulation programs, and AI use is growing. No medical humanities educator we spoke with uses virtual reality routinely — one ran a single bias-education module — and one uses AI, to generate ideas for classes rather than for students to interact with.

Virtual reality is used for specific purposes, including interprofessional communication. A community-college program runs high-fidelity multiplayer simulation across sixteen stations with unlimited student licensing, explicitly to teach team communication. A university lab has built team communication and de-escalation scenarios. An interprofessional education office runs acute-care scenarios pairing physicians and nursing students in headsets, with a debrief designed alongside the software. Another runs co-located immersive simulations in groups of three to five with a facilitator in the room. One educator ruled virtual reality out for one-on-one communication teaching as too labor-intensive.

One study tested whether it works. An interprofessional mass-disaster exercise, running three to four years, was the subject of a validity study asking whether the virtual-reality experience elicited the team communication behaviors it was designed to teach. It did and also found that learners observing the exercise on lap tops gained as much as those wearing headsets.

Several educators emphasized that virtual reality needs a clear value beyond what a desktop experience can provide, and most applications we heard about, whether bought or built, are available on desktop as well as in a headset, for accessibility.

Artificial intelligence use is growing. Twenty of the people we interviewed are using AI with learners, across simulation, interprofessional education, leadership, and faculty whose teaching spans approaches. A few interprofessional and simulation educators have grants to pilot virtual-reality-based AI communication applications, but AI is typically delivered by chat or two-dimensional avatars on a desktop, in both nursing and medical schools. One institutional leader is running a study on ambient artificial intelligence in live team rounds. A surgical educator described a different use again: teaching students to ask patients who are themselves using ChatGPT and Gemini — "show me your prompt strategy." Outside these interviews, we know of one program combining AI with art-museum-based teaching; it did not come up in the conversations reported here.

About a dozen educators, across simulation, interprofessional education, institutional leadership and multi-method teaching, raised concerns about learners being taught or assessed by AI agents. Their concerns center on what bots cannot do — be human, read tone, hold ambiguity — rather than on what they get wrong. One interprofessional educator described an AI-avatar empathy platform whose words are right but whose tone and delivery are not yet convincing.

On arts-based methods, simulation educators are largely unacquainted rather than unconvinced. Four of twenty-one referenced or expressed interest in arts-based teaching, and none had adopted it. Two of the four raised it themselves: one called it a valuable idea she had never formally used and said she should; another described it, unprompted, as having great potential. A third called an immersive version original and interesting, but was concerned that it might not hold the shared attention of a group looking together. A fourth had trained in narrative medicine but does not run a program; as the director of a simulation program, proposing curriculum is not his call.

Leadership views

Medical humanities educators often described leadership as the barrier to securing curricular time. The leaders we interviewed suggest something is shifting.

Among the deans, associate deans and directors we interviewed outside medical humanities, 7 run humanities or arts-based teaching in their curriculum, 2 are developing it, and 12 more expressed interest. Examples include museum-based visual thinking strategies; required art threaded through a curriculum for empathy; museum and observation exercises used as both learner and educator; visual-space work taught with architecture faculty; and a narrative medicine course. Only one declined interest. The topic did not come up in a dozen of these interviews, so this describes the leaders who discussed it rather than all of them.

Support comes with limits on time. Several leaders named a ceiling. One identified a specific share of preclinical hours as about right, and roughly triple that as too much to require, on the grounds that humanities compete for the same hours as clinical requirements. Two reduced multi-session sequences because students found them repetitive. One requires that anything added to the curriculum be balanced by something removed. One questioned time-intensive art-making as a use of learner hours.

What our interviews suggest

Medical humanities provides methods; simulation and interprofessional education hold assessment infrastructure. IPE and simulation programs have built instruments for adjacent capacities — behaviorally anchored observation rubrics, validated collaboration scales, structured debriefing protocols — alongside medical humanities whose outcomes have proven hard to capture.

Interprofessional education already shares several of the goals medical humanities pursues — empathy and perspective-taking in most of them, reflection in several, bias and tolerance of ambiguity more thinly. It also holds something medical humanities educators told us they work hard to secure: required, accreditation-mandated, team-based curricular time, in programs where every interviewee named an accrediting body. One caveat: close observation is not an interprofessional education goal in this study. One person named it.

Institutional leaders set the competency frameworks that this work must map onto. Humanities educators told us they do that mapping themselves, program by program. The leaders we spoke with were, in the main, not opposed to the work, which suggests the mapping could be done together rather than alone.

Combining methods is already endorsed on both sides. One faculty member describes museum-based looking as a building block used alongside simulation rather than in competition with it, and is explicit that the methods should build on each other rather than be compared. Another describes blending art and science. Among leaders: one trains empathy through a simulation progression

and through art at once, and does not treat arts work as peripheral; one has embedded an unconscious-bias simulation inside a four-year humanities stream; one folds humanities goals into a systems curriculum.

A next step. There is no single model for integrating medical humanities, and art-museum-based learning in particular, into health-professions curricula. What our interviews suggest is that there are many models worth comparing, and research worth sharing across medical humanities, interprofessional education and simulation, and with academic leaders. The shared goals are a foundation for working together on the skills that are essential but hardest to measure.

What this means for ViTaLS. These conversations were customer-discovery interviews, and they have shaped how we can build ViTaLS, our immersive virtual-reality approach to teaching foundational communication skills using Visual Thinking Strategies to interprofessional groups of students. What we heard has pointed us toward developing clinically relevant modules designed for specific points in a curriculum, built-in assessment, and delivery that does not depend on a headset.

We welcome your questions, comments or additions to the report and our plans for ViTaLS. They can be sent to robin@mediacombo.net.

Named Skills Table is attached.

Communication Skills Named by Participants

	Community					
Skills	Med Hum (28)	Simulation (21)	IPE (13)	Inst Lead (13)	Multi-method (11)	Total naming it (86)
SHARED ACROSS COMMUNITIES						
Communication (any)	24	21	13	13	11	82
Empathy / perspective-taking	18	14	9	8	8	57
Communication with patients	10	17	7	7	7	48
Communication within teams	5	10	13	4	5	37
Listening	6	6	1	0	4	17
Bias / structural awareness	8	5	2	1	1	17
Cultural humility / cross-cultural	3	2	2	2	1	10
CONCENTRATED IN MEDICAL HUMANITIES						
Close observation	21	1	1	6	4	33
Reflection	17	2	2	1	1	23
Professional identity	16	0	2	2	2	22
Tolerance of ambiguity	12	2	2	2	3	21
Wellbeing / resilience	11	1	0	5	2	19
Ethics / ethical reasoning	6	0	0	2	1	9
Curiosity / creativity	4	0	0	0	0	4
Clinical / diagnostic reasoning	3	0	0	0	1	4
Self-awareness / imposterism	2	0	0	0	1	3
CONCENTRATED IN SIMULATION AND IPE						
Difficult conversations / bad news	2	8	3	2	2	17
Speaking up across hierarchy	0	2	2	0	1	5
De-escalation	0	2	1	1	0	4
THIN EVERYWHERE						
Humility	3	2	0	1	1	7
Leadership	2	2	0	0	0	4

Number of people who named the skill as something they teach.