

Across the Silos: Teaching Communication Skills in Health Professions Education

Executive Summary

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 a proven, 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 interviews, with people from 49 organizations. 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 of the 86 held a leadership title: 22 at the level of an institution or a national body, and 42 directing a program, course, or center. Seventeen were faculty without a directing title, and five ran simulation or extended reality facilities.

Thirty-three of them lead or teach medical humanities, 24 in leadership roles and 9 as faculty. 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, led by 30 physicians, 14 nurses and advanced practice nurses, and 8 physical therapists. The rest were humanities scholars, engineers, psychologists, assessment specialists, instructional designers, and a former art museum director. At least ten of the clinicians hold arts or humanities credentials of their own.

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.

Sixteen of the 86 came from two large universities, but from many different schools within them. That reflects where an existing collaboration and a chain of referrals led us, not a deliberate weighting.

What We Learned

Educators across these communities teach different skills, use different terms and methods, and measure different outcomes but they also share many of the same goals and the same challenges. The full report is available here: [\[link\]](#).

Communication is widely mandated, and the word covers many different skills. Our interviewees named fifteen accrediting and standards bodies that require it, with at least three distinct goals among them: communication with patients, within teams, and with publics and audiences. A fourth is emerging in nursing standards: communication through telehealth and other remote encounters. The challenge is that the same word—communication—can obscure how different the underlying skills and goals actually are. **(Skills table attached.)**

Humanities-based capacities appear in competency frameworks, often in broad terms. Close observation, empathy, reflection and tolerance of ambiguity are named, but often without the observable behaviors needed for assessment.

Medical humanities educators described translating their work into the nearest available competency. That can secure a place in the curriculum but obscure what they are actually teaching. For example, a museum session may be recorded as teaching communication when the educator believes they are developing close observation.

There is no single model for integrating humanities into the curriculum. We found programs that integrate this work into required content across four years. One folds humanities goals into a health-systems pillar without the humanities label; others keep it in a separate track. Because the methods and their placements differ widely, so does the recommended dose. Our interviews showed us a range of models rather than one ideal approach.

All three communities teach communication in several ways, at several points in a curriculum. Humanities educators work through art, literature, narrative and reflection. Simulation and interprofessional programs work through standardized patients, team scenarios and structured debriefing, and the targets they name are more often clinical skills that can be observed and scored. We were surprised standardized patients are the one method mentioned by all five groups of interviewees.

Reflection and debriefing serve the same purpose under different names. Medical humanities educators call it reflection, and 19 of 28 build it into their teaching. Simulation and interprofessional educators call it debriefing and describe it as structured and sometimes required by accreditation — one said plainly that communication lives in the debrief. One educator has proposed combining museum-based looking with simulation debriefing.

The communities often work separately, sometimes inside the same institution. We found examples of educators operating in parallel without knowing about one another. Seven interviewees described a program on their own campus they had no connection to: five interprofessional educators describing an arts or humanities program elsewhere in their university, and two humanities faculty asking about their own simulation center. Where the divide is bridged, individuals could provide the bridge.

Measurement matters to everyone and is hard for everyone. Interprofessional education and simulation have validated instruments in routine use, but educators told us they want better ones. Medical humanities named measurement as unsolved more often than the other communities and described existing scales as not capturing what the work is intended to accomplish. Across all three communities, empathy and tolerance of ambiguity are particularly difficult to measure.

Technology use differs sharply across the communities. Immersive virtual reality is already routine in most of the simulation programs we learned about,

used for team communication, de-escalation and interprofessional scenarios. AI is growing across simulation, interprofessional education and leadership, most often through chat or two-dimensional avatars rather than headsets. By contrast not one of the medical humanities educators we spoke with use virtual reality with students, and one uses AI, to generate teaching ideas. 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.

Academic leadership views are shifting. Of the 33 academic leaders we interviewed outside medical humanities, 7 run humanities or arts-based teaching in their curriculum, 2 are developing it, and 11 more expressed interest in it. Only one declined. What leaders manage, however, is scarce curricular time. These leaders described different limits and different ways of deciding what earns a place in the curriculum. The topic did not come up in every interview.

Every new school we spoke with built humanities in as required content. Four of these schools opened within the past eight years, and all four built humanities into the curriculum from the start — as required or threaded content rather than as electives. One did so within a compressed three-year curriculum. Two designed a museum partnership in from the beginning. None of them described the constraints that established programs did: competing for curricular time, depending on a single champion, or losing a course in a revision.

What our interviews suggest. The three communities each bring something different to the table. Medical humanities provides invaluable methods for developing capacities such as observation, reflection, empathy, and tolerance of ambiguity. Simulation holds assessment infrastructure. Interprofessional education holds required, accreditation-mandated curricular time that humanities educators told us they work hard to secure. Institutional leaders sit at the intersection. They define or influence the competency frameworks that this work needs to map onto and, based on the leaders we interviewed, are generally not opposed to the work. There is no single model for integrating medical humanities into health-professions curricula, but there are many models worth comparing, and research worth sharing to promote collaboration across all three communities and with academic leaders.

What this means for ViTaLS. These conversations were customer-discovery interviews, and they have shaped how we would 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, collaborating with medical humanities, simulation and interprofessional educators.

We welcome your comments, questions or additions to any portion of this summary. They can be sent to robin@mediacombo.net.

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.