# Communication skills competencies: definitions and a teaching toolbox

Elizabeth A Rider[1] & Constance H Keefer[2]

BACKGROUND Doctors' interpersonal and communication skills correlate with improved health care outcomes. International medical organisations require competency in communication skills. The Accreditation Council for Graduate Medical Education (ACGME) developed a toolbox for assessing this competency and 5 others, yet none initially for teaching these skills.

PURPOSE AND METHODS The original focus in the development of the ACGME competencies was evaluation. This paper represents a significant step toward defining methods for teaching communication skills competencies. A total of 16 medical education leaders from medical schools worldwide, participating in the 2003 Harvard Macy Institute Program for Physician Educators, worked together to: (1) further define the ACGME competency in interpersonal and communication skills; (2) delineate teaching strategies for each level of medical education; and (3) create a teaching toolbox to integrate communication skills competencies into medical curricula. Four subgroups defined subcompetencies, identified teaching strategies for undergraduate, graduate and postgraduate medical training and brought their work to the larger group. The expanded communication competencies and teaching strategies were determined by a consensus of the larger group, presented to 80 Harvard Macy Scholars and Faculty for further discussion, then finalised by consensus.

CONCLUSION The teaching toolbox expands the ACGME core communication competencies, adds 20 subcompetencies and connects these competencies to teaching strategies at each level of medical training. It represents the collaboration and consensus of a diverse international group of medical education leaders in a variety of medical specialities and institutions, all involved in teaching communication skills. The toolbox is applicable globally across different settings and specialities, and is sensitive to different definitions of health care.

KEYWORDS *communication; clinical competence/*standards; teaching/*methods; curriculum; physician–patient relations.

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[1]Harvard Medical School; Director of Programs for Communication Skills, Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital; Co-Director, Communication Skills Teaching Program, Harvard Medical School; Faculty, Program to Enhance Relational and Communication Skills (PERCS), Children's Hospital, Boston, Massachusetts USA
[2]Harvard Medical School; Attending in Newborn Medicine, Brigham and Women's Hospital; and Faculty, Brazelton Institute and Touchpoints Center, Children's Hospital, Boston, Massachusetts USA

*Correspondence*: Dr EA Rider, Harvard Medical School – Pediatrics, 1153 Centre Street, Suite 31, Boston, MA 02130, USA. Tel: 617 795-0385; Fax: 617 522 6366; E-mail: elizabeth_rider@hms.harvard.edu

## BACKGROUND

Evidence-based studies show that doctors' interpersonal and communication skills have a significant impact on patient care and correlate with improved health outcomes and health care quality.[1–3] Ineffective communication skills are associated with malpractice claims and suits[4] and medication errors.[5]

Communication is a core clinical skill that can be taught and learned. A doctor performs 160 000–300 000 interviews during a lifetime career, making the medical interview the most commonly performed procedure in clinical medicine.[6]

Competency in interpersonal and communication skills is required at all levels of medical training.[7–11] Medical school guidelines [Institute for International


 

## Overview

**What is already known on this subject**

International medical organisations require competency in communication skills. These skills correlate with improved health care outcomes. The ACGME developed a toolbox for assessing this competency and 5 others, yet none initially for teaching.

**What this paper adds**

Our work represents the consensus of an international group of medical education leaders. We expanded core competencies in communication skills, added 20 subcompetencies, and created a toolbox of teaching strategies for each level of medical training. The toolbox is applicable globally across different settings, specialities and health issues.

**Suggestions for further study**

Future research should examine which teaching methods optimise improvement of interpersonal and communication skills and health care outcomes.

Medical Education (IIME)[7], Liaison Committee on Medical Education (LCME)[8], General Medical Council (GMC),[12] Committee on Accreditation of Canadian Medical Schools (CACMS)[9] and American Association of Medical Colleges (AAMC)[13]] reflect increasing international recognition of the importance of teaching and assessing communication skills during undergraduate medical training. As of 2004, US medical students and graduates of international medical schools who are applying to train or practice in the United States are required to demonstrate competence in clinical, interpersonal and communication skills on the US Medical Licensing Examination (USMLE) Clinical Skills Examination.[10] Consensus statements (Kalamazoo,[14] Toronto,[15] International[16]) elucidate further communication skills competencies.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) endorsed 6 general competencies that postgraduate residents should demonstrate.[17] During the same year, the American Board of Medical Specialties (ABMS) adopted the same competencies for practising clinicians. The ACGME developed a toolbox for assessing this competency, yet none initially for teaching these skills.[18]

**Educational objectives**

Our objectives were to: expand and define further the ACGME competency in interpersonal and communication skills and to identify subcompetencies within each communication skills competency; delineate teaching strategies for each competency for each level of medical education; and create a teaching toolbox to integrate communication skills competency criteria into medical training.

## METHODS

A total of 16 medical education leaders from medical schools worldwide, all scholars selected to participate in the 2003 Harvard Macy Institute Program for Physician Educators, held a series of meetings to expand the original ACGME text for the interpersonal and communication skills competency as an integral part of the curriculum design theme of the programme.

We used an expert focus group model with further refinement and development of subcompetencies by subgroups, followed by review and consensus of the focus group, further review by a large group of medical education experts and scholars, and then final consensus of the expert focus group. The expert focus group expanded the original 3 AGCME communication competencies, and created 20 subcompetencies in interpersonal and communication skills (Table 1).

From the expert focus group, 4 subgroups, determined by interest and expertise, met to define further the communication competencies and to develop subcompetencies. Each subgroup presented draft language for its chosen competency to the larger group for clarification and revision. Subgroups were then charged with identifying preferred teaching strategies for their communication competency and subcompetencies for 3 levels of training: undergraduate medical education (UME), graduate medical education (GME) and continuing medical education (CME). Preferred teaching strategies were those that: (1) participants had used effectively themselves; (2) were supported by studies of effective

*Table 1 Original and expanded ACGME language for interpersonal and communication skills competencies*

| **Original ACGME language,**[17] | **Expanded competencies and subcompetencies** |
|---|---|
| Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and professional associates. Residents are expected to: | |
| **1. Create and sustain a therapeutic and ethically sound relationship with patients** | **1. Create and sustain a relationship that is therapeutic for patients and supportive of their families**<br>(a) Be 'present', paying attention to the patient, caring for the patient, and working collaboratively and from strengths<br>(b) Accept and explore the patient's feelings, including negative feelings<br>(c) Provide a sustainable relationship that allows for repair when mistakes are made, and includes authenticity, honesty, admission of, and sorrow for, mistakes<br>(d) Communicate with the patient's family honestly and supportively. In some cases (e.g. paediatrics and geriatrics) the doctor–patient relationship is imbedded in and extends to the family; in other circumstances the doctor's relationship with the family may be separate from that with the patient |
| **2. Use effective listening skills and elicit and provide information using effective non-verbal, explanatory, questioning, and writing skills** | **2. Use effective listening skills to facilitate relationship. Elicit and provide information using effective non-verbal, explanatory, questioning, and writing skills. Respond promptly to patients' queries and requests**<br>(a) Demonstrate effective listening by hearing and understanding in a way that the patient feels heard and understood. Use non-verbal cues such as nodding, pausing, maintaining eye contact, and verbal skills including back-tracking, reflecting, mirroring<br>(b) Recognise the patient's preferred (or current) mode of communication and selectively choose the most effective mode of communication for the situation. Assess patient's understanding of problem and desire for more information; explain using words that are easy for the patient to understand<br>(c) Understand the patient's perspective, including the patient's individual concerns, beliefs, and expectations; respect the patient's cultural and ethnic beliefs, practices and language<br>(d) Create an atmosphere of mutuality and respect through patient participation and involvement in decision-making<br>1. Include patient in choices and decisions to the extent he or she desires<br>2. Collaboratively set agenda for encounters<br>3. Negotiate mutually acceptable plans in partnership with patient |
| **3. Work effectively with others as a member or leader of a health care team or other professional group** | **3. Work effectively with others as a member or leader of the health care team or other professional group. In all areas of communication and interaction, show respect and empathy towards colleagues and learners**<br>(a) Demonstrate excellent collaboration and cooperation with other members of the health care team involved in the patient's care<br>1. Be specific with questions asked of, and answers given to, colleagues; ensure that the communication is clearly understood<br>2. Include adequate and complete information in all documentation and written communication about a patient's care<br>3. Resolve conflict and give constructive feedback on mistakes.<br>(b) Communicate clearly in the role of teacher<br>1. Assess the educational needs of learners<br>2. Collaboratively set realistic learning expectations with learners<br>3. Identify and eliminate barriers in team teaching; maintain an appropriate balance between patient care and teaching<br>4. Offer, seek, and accept honest, constructive and timely feedback |

teaching methods; and/or (3) made sense to the participants in their deliberations on how 'level of training' would optimise or constrain effective teaching strategies.

During additional meetings, the larger group developed a draft of the interpersonal and communication skills competencies and their subcompetencies, with teaching strategies for each. The draft of the expanded communication competencies, subcompetencies and teaching strategies were determined by consensus of the expert focus group and presented to 80 Harvard Macy Scholars and Faculty for further discussion. The final competencies, subcompetencies and teaching strategies were determined by consensus of the expert focus group.

*Table 2 Interpersonal and communication skills: a teaching toolbox*

| Interpersonal and communication competencies | Teaching strategies* by level of training |
|---|---|
| **1. Create and sustain a relationship that is therapeutic for patients and supportive of their families** | **UME†: observation (in real time) with feedback; role modeling; videotape with standardised patient; workshops.**<br>Also mentioned: problem-based learning (PBL); narrative (reading and writing); mentoring; feedback from standardised patient; role play; personal self-reflection in small group; lecture; mini-lecture; setting a corporate culture<br>**GME‡: observation in real time with feedback; role modelling; self-assessment; videotape**<br>Also mentioned: workshops; small group discussion of cases; simulated patient; web-based module<br>**CME§: narrative (reading and writing); self-assessment; videotape**<br>Also mentioned: workshops; role play; Balint group; simulation |
| **2. Use effective listening skills to facilitate relationship. Elicit and provide information using effective non-verbal explanatory, questioning, and writing skills. Respond promptly to patients' queries and requests** | **UME, GME, CME: observation with feedback in small group or PBL; role play; bedside teaching; narrative (reading and writing); keeping journals; microskills; group OSCE; web-based learning**<br>Content complexity and difficulty increase from UME to GME to CME, while the strategies remain the same. |
| **3. Work effectively with others as a member or leader of the health care team or other professional group. In all areas of communication and interaction, show respect and empathy towards colleagues and learners** | **UME: observation and feedback with standardised learner and colleagues; observation and feedback (real time); role play**<br>Also mentioned: videotape; microteaching; workshops; role modelling; keeping journals; self-assessment.<br>**GME: role modelling (on rounds, in clinic); mentoring; observation with feedback; workshops**<br>Also mentioned: self-assessment; videotape; 360-degree observation of the team by the team used as data for a workshop<br>**CME: workshops; self-assessment**<br>Also mentioned: 360-degree evaluation; case discussion |

*Teaching strategies are listed in order of most strongly recommended. †UME = undergraduate medical education (medical students); ‡GME = graduate medical education (interns, residents, fellows); §CME = continuing medical education (practising physicians, faculty).

## RESULTS

The final interpersonal and communication skills competencies and teaching strategies for each level of medical education are presented in Table 2.

At each education level and for each competency, the teaching strategy chosen most frequently was observation (by preceptors or peers), in real time or on videotape, with feedback.[19–21] Self-assessment, including keeping journals and narrative work,[22–24] was next, and was identified for all 3 competencies at all educational levels. Role-play[25] was listed as a teaching strategy for all 3 educational levels for competency 2 (uses effective listening skills and provides information to patients). Role modelling[26,27] was identified for competencies 1 (creates a therapeutic relationship) and 3 (works well with other members of the health care team) at the UME and GME levels, but not at the CME level. Competencies 1 and 3 had the greatest number and variety of recommended teaching strategies across all levels, 17 and 13, respectively. In contrast, competency 2 (uses effective listening skills and provides information to patients) had 8 teaching strategies that were the same, but with increasing content complexity, across the 3 levels of training.

Four unique teaching methods were identified for several of the subcompetencies: Balint Group[28,29] for competency 1c (sustains a relationship); web-based learning[30,31] and group objective structured clinical examination (OSCE)[32,33] for competency 2 (uses effective listening skills and provides information to patients); and '360-degree team-on-team reflection'[34,35] for competency 3 (works well with members of the health care team). The Appendix provides descriptions of teaching strategies with references, and includes those strategies recommended most frequently and those considered unique and that readers may not be as familiar with.

## DISCUSSION AND IMPLICATIONS

A group of medical educators and leaders from around the world expanded and further defined the

ACGME competency in interpersonal and communication skills and developed 20 subcompetencies. The group created a teaching toolbox for interpersonal and communication skills that connects these competencies to teaching strategies at each level of medical training.

The original focus of the ACGME competencies was assessment,[18] with the hope that teaching would follow competency evaluation. This paper represents a significant step toward defining methods for teaching interpersonal and communication skills competencies. The next task is to operationalise and define behaviourally the expanded competencies, prioritising and translating for the learner the skills needed for effective communication and development of the doctor–patient relationship. A modified Delphi approach to prioritise teaching strategies further may prove useful. Continued development of integrated curricular programmes in these skills follows.[36,37] Finally, research to show that the communication competencies are learned and used effectively is necessary, followed by the prospective measurements of objective outcomes.

The strength of the communication skills teaching toolbox lies in the fact that it builds on the ACGME competency language and represents the collaboration and consensus of a diverse international group of educational leaders working in a variety of medical specialities and institutions, all experienced in teaching communication and interpersonal skills. The toolbox is applicable globally across different settings, specialities and health issues, and is sensitive to different definitions of health care. It provides a framework for doctor educators to teach humane medicine.

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## SUPPLEMENTARY MATERIAL

The following supplementary material is available for this article online:

**Appendix S1.** Description of selected teaching strategies for interpersonal and communication skills.

**Appendix S2**. Participants' List.

This material is available as part of the online article from http://www.blackwell-synergy.com

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