UK consensus statement on the content of communication curricula in undergraduate medical education

Martin von Fragstein,[1] Jonathan Silverman,[2] Annie Cushing,[3] Sally Quilligan,[2] Helen Salisbury[4] & Connie Wiskin[5] on behalf of the UK Council for Clinical Communication Skills Teaching in Undergraduate Medical Education

CONTEXT The teaching and assessment of clinical communication have become central components of undergraduate medical education in the UK. This paper recommends the key content for an undergraduate communication curriculum. Designed by UK educationalists with UK schools in mind, the recommendations are equally applicable to communication curricula throughout the world.

OBJECTIVES This paper is intended to assist curriculum planners in the design, implementation and review of medical communication curricula. The document will also be useful in the education of other health care professionals. Designed for undergraduate education, the consensus statement also provides a baseline for further professional development.

METHODS The consensus statement, based on strong theoretical and research evidence, was developed by an iterative process of discussion between communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education.

DISCUSSION How this framework is used will inevitably be at the discretion of each medical school and its implementation will be determined by different course designs. Although we believe students should be exposed to all the areas described, it would be impractical to set inflexible competency levels as these may be attained at different stages which are highly school-dependent. However, the framework will enable all schools to consider where different elements are addressed, where gaps exist and how to generate novel combinations of domains within the communication curriculum. It is hoped that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

KEYWORDS consensus; *education; medical; undergraduate; *communication; teaching/*methods; Great Britain.

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INTRODUCTION

The teaching and assessment of clinical communication skills have become central components of undergraduate medical education in the UK.[1–5] This paper recommends the key content for an undergraduate communication curriculum. Although the recommendations have been designed by UK educationalists with UK medical schools in mind, they are equally applicable to communication curricula elsewhere in the world.

This document was developed by an iterative process of discussion between communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Clinical Communication Skills Teaching in Undergraduate Medical

[1]School of Graduate Entry Medicine & Health, University of Nottingham, Derby, UK
[2]School of Clinical Medicine, University of Cambridge, Cambridge, UK
[3]Clinical Communication and Learning Skills Unit, Barts and the London School of Medicine and Dentistry, London, UK
[4]Department of Primary Care, Oxford University, Oxford, UK
[5]Department of Primary Care & General Practice, University of Birmingham, Birmingham, UK

Correspondence: Jonathan Silverman, School of Clinical Medicine, Box 111, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0SP, UK. Tel: 00 44 1223 769290; Fax: 00 44 1223 769289; E-mail: js355@medschl.cam.ac.uk

Overview

What is already known on this subject

The teaching and assessment of clinical communication are now central components of undergraduate medical education in the UK.

What this study adds

This consensus statement from all 33 UK medical schools recommends the key content for the undergraduate clinical communication curriculum. By utilising this benchmark, medical schools will be able to develop the range of learning experiences all students should encounter to be sufficiently qualified for a career in medicine. These recommendations are equally applicable throughout the world and in the education of other health care professionals.

Suggestions for further research

The UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education will next produce written and video-format guidance on the teaching and assessment of the individual domains delineated within this statement.

Education, established in 2005 (details on the current representatives of the UK council are available online as Supporting Information). The document is intended to assist curriculum planners in the design, implementation and review of medical communication skills curricula. We hope that it will also be useful in the education of other health care professionals.

Designed for undergraduate education, the recommendations described here also provide a baseline for further professional development.[6–8] The process of developing and improving competency in the complex area of medical communication skills is something that all health care professionals must engage with throughout their careers.

How this framework is used will inevitably be at the discretion of each medical school. Its implementation will be determined by different course designs. However, the framework will enable all schools to consider where different elements are addressed, where gaps exist and how to generate novel combinations of domains within the communication curriculum. Although we believe that students should be exposed to all the areas described, we consider that it would be impractical to set inflexible competency levels because these may be attained at different stages that are entirely school-dependent. By not defining competencies, we have more readily included areas which are important but which resist easy measurement, such as integrity and respect.

We hope that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

THE CONSENSUS STATEMENT

The consensus statement consists of a diagrammatic representation of the domains of clinical communication followed by a more detailed written description. The statement was generated through a process of iterative discussion between communication leads from all 33 UK medical schools which aimed to produce an empirical model of practical relevance to curriculum design and implementation. It is also based on strong theoretical and research evidence. Comprehensive evidence exists to guide the modern practice of communication skills teaching and learning[9] and over 30 years of accumulated research linked to outcome has guided the choice of communication domains, tasks, skills and issues to include in the statement.[10–14]

COMMUNICATION CURRICULUM WHEEL

A central component of this consensus statement is a diagrammatic representation of the content of clinical communication curricula in undergraduate medical education. In this diagram, the key domains of clinical communication are shown as concentric rings, starting in the centre with ‘respect for others’ and moving outwards through the specific domains of communication learning (Fig. 1). These domains are set within a milieu of four over-riding principles which govern not only communication, but all areas of medicine.

The specific components of each domain are then delineated within each ring. By rotating the rings independently, the communication curriculum planner can in effect ‘dial a curriculum’ by, for instance, dialling up how to teach the specific situation of explanation and planning about an elderly patient, to a relative over the telephone.

This communication curriculum wheel enables curriculum planners to take a helical rather than a

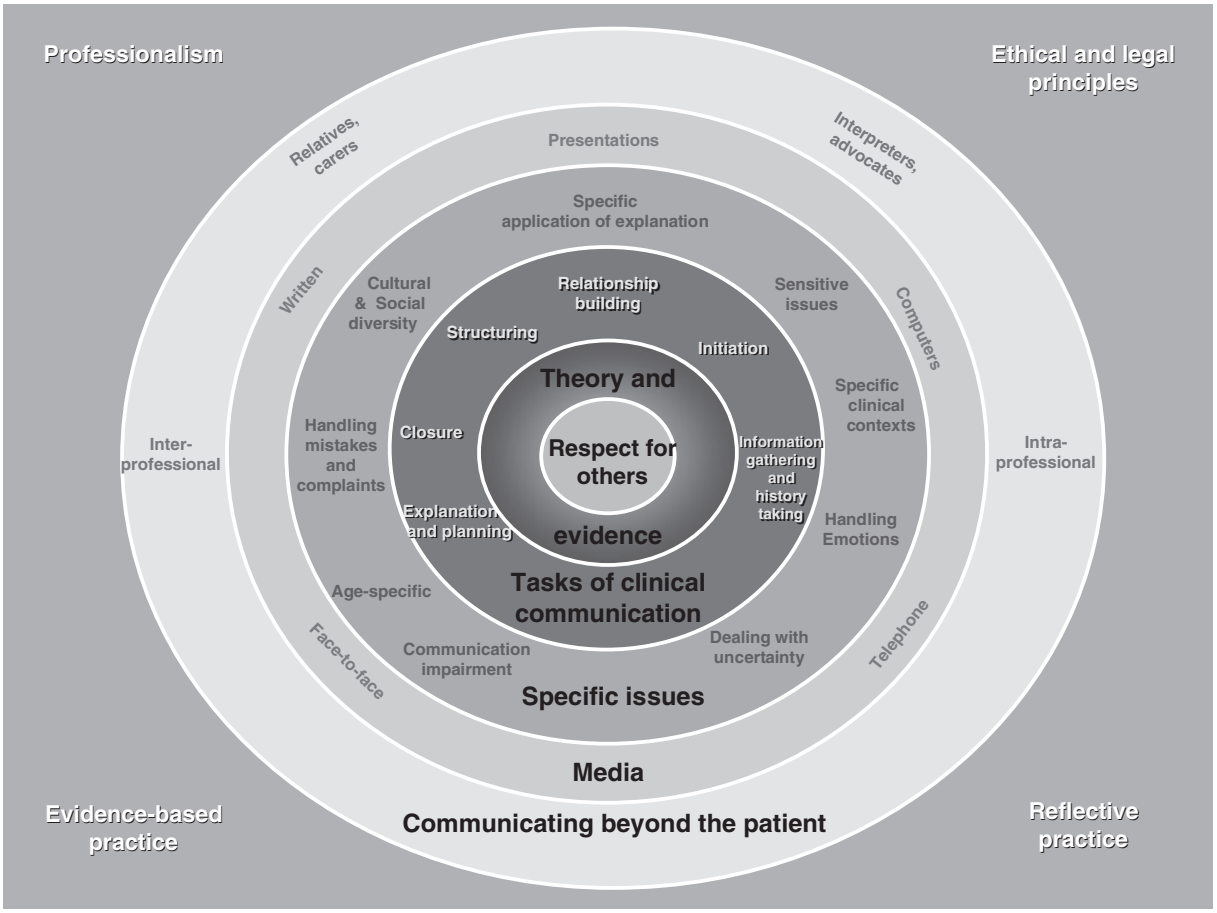

Figure 1 Communication curriculum wheel

linear approach to clinical communication teaching. The dial-a-curriculum model not only enables linkage of the key domains, but also explicitly encourages a reiterative process. A properly planned communication curriculum provides opportunities for learners to review, refine and build on existing skills while simultaneously adding new skills and increasing complexity. If ongoing, helical communication programmes do not run throughout the course, students will fail to master communication.[15]

In the text below, we expand and illustrate the domains and components of the diagram.

DOMAINS OF CLINICAL COMMUNICATION

Respect for others

Underlying all other components of effective clinical communication is respect. Students need to embrace respect for all patients and a commitment to equality in order to be able to communicate effectively and flexibly with individuals, regardless of social, cultural or ethnic backgrounds or disabilities. Our society, like others worldwide, comprises an increasingly diverse mix of cultural groups with unique health beliefs and aspects of individuality that impact on the interaction between doctor and patient. These changes in society emphasise the need for health care professionals to develop respectful partnerships with their patients and colleagues.

Theory and evidence of communication skills

Although this paper largely focuses on the acquisition of skills, these skills are underpinned by a significant body of evidence and theoretical frameworks.[10,11,16] Learners need to be aware of the evidence base for communication and be capable of interpreting and acting upon it appropriately. This includes an awareness of the literature related to:

- patient satisfaction;
- recall;
- adherence and concordance;
- wellbeing;
- physical outcome;

- psychological outcome;
- medico-legal issues, and
- patient safety and reduction of error.

Students need to understand that effective communication is part of an integrated approach to practice in health care and that it stands alongside and is as important to good practice as clinical knowledge and practical skills.

The theoretical approach of patient-centredness[17] has been demonstrated to be a paramount feature of high-quality care and should be a central component of any communication curriculum. Students need to develop a commitment to partnership and the concept of patient autonomy which puts patient choices and self-determined needs at the core of health care interactions.

Tasks and skills of the clinical interview

Tasks

The importance of appreciating the nature and tasks of the consultation should not be underestimated. Students should strive to understand not only the purpose of the consultation, but also how various tasks within the consultation contribute and apply to achieving the overall goal. Effective communication requires a keen understanding of the structure of the medical interview.

As communication is generally purposive, most of the activities of the medical interview can be taught as tasks. A number of well-established consultation models and recommendations list these tasks.[18–24] Experienced doctors operate flexibly and may choose from a mixture of models. The tasks below are typically associated with these models:

- establishing and building a relationship;
- initiating (i.e. opening the consultation and setting the agenda);
- establishing, recognising and meeting patient needs;
- gathering information;
- eliciting and considering the patient's world view;
- conducting a physical examination;
- formulating and explaining relevant diagnoses;
- explaining, planning and negotiating;
- structuring, signposting and prioritising, and
- closing (ending the interview and setting up the next meeting).

These communication *process* tasks are closely linked to the *content* of the medical interview. For instance, the communication task of gathering information, which is achieved via a set of specific process skills, enables the practitioner to obtain the content of the medical history. These two elements of content and process are inextricably linked and require an integrated approach in the medical curriculum.

Skills

There are a number of discrete, observable, specific behavioural skills relevant to the execution of each of the separate tasks above. Examples of these skills include:

- eye contact;
- facial expression;
- attentive listening;
- screening;
- appropriate balance of open and closed questions;
- faciliation;
- empathic reflection;
- responding to cues (both verbal and non-verbal);
- summarising;
- signposting;
- determining the patient's starting point when giving information;
- chunking information, and
- checking the patient's understanding.

These skills form the backbone of effective clinical communication curricula: a full list of these vital skills can be found in the consultation models referenced above. It is important that students understand and can put into practice these key communication skills as delineated in the various models.

The task and skills of 'relationship building' need special emphasis. Learners need to understand and appreciate the particular nature of the doctor's relationship with the patient, including the imbalance of power that is inherent in the consultation. The importance of the therapeutic relationship and the need for professional boundaries require particular attention. Students must recognise the importance of building and maintaining a rapport with the patient and must develop the skills required to put this intention into action.

Specific issues

There are many challenging contexts and situations for doctors when they communicate with patients. The skills necessary to carry out the tasks of the consultation provide a secure platform from which to tackle specific communication issues. The challenge for the

communication curriculum is to deepen learners' understanding of these core skills and to encourage them to use these skills flexibly and responsibly in a variety of specific situations. The following specific areas should be covered within the curriculum.

Age-specific areas

The curriculum should cover communication with children and parents, adolescents, and elderly patients.

Cultural and social diversity

Teaching in the curriculum should include issues related to: ethnicity and nationality; language; religion; sexuality; gender; socioeconomic status; disability; educational status, and spirituality.

Handling emotions and difficult questions

The curriculum should include teaching that enables students to learn how to handle difficult emotions, such as distress; fear; anger; aggression; denial; collusion, and embarrassment.

Skills for specific clinical contexts

The curriculum should include the teaching of skills to be used within specific clinical contexts, such as: in psychiatry (uncovering hidden depression and assessing suicidal risk; working with psychotic patients; working with patients with cognitive impairment; dealing with alcohol and substance abuse); when working in emergency medicine (dealing with aggressive and violent patients; time management and prioritisation).

Specific application of explanation and planning skills

The curriculum should include skills pertaining to seeking informed consent; risk management; health promotion, and behaviour change.

Dealing with uncertainty

Issues of uncertainty require skills that enable the health care professional to deal with: issues concerning uncertain prognosis; changing relationships with patients (the expert patient; the well-informed patient) and medically unexplained symptoms.

Sensitive issues

Medical professionals are also required to assimilate skills that enable them to: break bad news; discuss death, dying and bereavement; talk about sex; explore a patient's gynaecological history, and discuss issues that involve stigmatisation, such as child abuse, HIV infection and mental illness.

Communication impairment

The curriculum must also enable students to acquire the skills required to communicate with patients who have a sensory impairment such as a hearing impairment or a visual impairment; an expressive impairment; or learning disability.

Media

Students need to be able to communicate effectively in spoken, written and electronic formats. Five areas should be addressed within the curriculum.

Face-to-face communication requires students to:

- develop an awareness of environmental factors, both physical and social, and
- be aware of the use of body language.

Telephone communication requires students to:

- understand the specific demands and adaptations required in communication over the telephone.

Written communication requires students to:

- record an accurate initial patient assessment and subsequent daily progress notes in clear and concise written language;
- write discharge and referral letters in a manner that is well structured, comprehensible, comprehensive and clear, and
- write notes, drug charts and death certificates, legibly, clearly and accurately.

Computer-based and electronic communication requires students to:

- have sufficiently competent IT skills to ensure patients' electronic records are well maintained;
- be familiar with computerised patient records, prescribing and referral systems, and
- be aware of issues pertaining to the use of fax and e-mail for communication (e.g. confidentiality).

Making presentations requires students to:

- present patient information in clinical settings in an organised, articulate and coherent manner, and

- present clinical and academic information to large groups.

Communicating beyond the patient

Clinicians need to communicate with relatives, carers and colleagues from a range of health and social care professions and other agencies, while maintaining appropriate patient autonomy and confidentiality.

Individuals who accompany the patient to the consultation, whether relatives, carers, advocates or interpreters, present added challenges to communication. Clinicians also need to collaborate with other doctors and negotiate in the patient's best interests: learners require the opportunity to explore which skills and attitudes are needed to work effectively with medical colleagues. Students will work with the wider health care team, with statutory and voluntary organisations and with management groups. This requires a commitment to communicate effectively and work co-operatively and respectfully with other professionals and organisations. To achieve this, learners will need to be able to identify enabling factors and barriers to effective team-working. Whenever possible, teaching on interprofessional team-working should be planned and taught interprofessionally.

Students need to address the following four areas.

Relatives and carers

Communication with relatives and carers requires students to: explore how to negotiate the inclusion of a third party; enable the patient to present his or her problem freely; consider how to maintain confidentiality, and understand how to manage the dynamics of a triadic interview.

Advocates and interpreters

Students must learn the skills necessary to: work with patient advocates; work with professional and lay interpreters; negotiate and define the parameters of the roles involved, and work effectively within the cultural and practical constraints contained in this type of interview.

Intra-professional

Intra-professional communication requires students to be able to: produce clear, comprehensible oral and written communication; understand the issues relating to handover and ward round presentations; understand techniques for being appropriately assertive when working with a colleague; appreciate how to express concerns to a colleague or peer about his or her performance; be aware of General Medical Council guidelines regarding the responsibility to act if there is any suspicion that a colleague is behaving in a manner that may put patients at risk; deal with complaints and medical errors (understand the mechanisms by which complaints from patients, relatives or staff are dealt with; understand the systems that exist for reporting medical errors and the roles these may have in improving patient safety; consider the impact that being the subject of a complaint or responsible for an error may have on an individual, and the sources of support available).

Inter-professional

Inter-professional communication requires students to be able to: understand other team members' values, roles, expertise and responsibilities and consider how to collaborate effectively; understand the issues that promote effective communication and continuity of care across the primary or secondary care interface, managing and embracing, conflicting sharing information, and maintaining confidentiality.

SUPPORTING PRINCIPLES

The domains described above are set within a milieu of over-riding principles which govern all areas of medical practice. Communication curricula must exist within the following four areas, which will also govern the rest of the undergraduate curriculum.[25–27] This common background underlines the necessity for collaborative and integrative planning across the undergraduate curriculum as a whole.

Reflective practice

Reflective practice includes personal self-awareness and dealing with uncertainty, whether concerning diagnosis, optimal management or prognosis. This requires the student to develop self-awareness and the ability to: recognise areas of personal challenge; understand the extent to which personal views and values can clash with professional responsibility and the potential impact this might have on communication with patients; recognise his or her own limitations; understand when there is a need to refer

to senior colleagues; appreciate the need to respond constructively to feedback; understand professional boundaries; consider personal care and safety. The student also needs to appreciate how to cope with uncertainty by understanding the stress that uncertainty may bring, and reflecting on personal coping strategies.

Professionalism

Students need to develop a professional approach that incorporates integrity, honesty and probity and facilitates the development of an understanding of professional boundaries.

Developing attributes of integrity, honesty and probity will allow students to: accept the moral and ethical responsibilities involved in providing care to individual patients and communities; appreciate the unequal balance of power in the doctor–patient relationship and the need to always act in the patient's best interest; be willing to face difficult situations, including those involving uncertainty, risk and error and communicate in ways that safeguard patient safety; be honest and trustworthy in all communication, including in written reports and documentation, and be responsible for maintaining confidentiality and appropriate sharing of information.

Understanding professional boundaries will enable students to: be aware of the boundaries that exist in the clinical relationship; understand the need for such boundaries, and appreciate the factors that maintain them, such as formality of language and dress, the nature of the clinical environment and the necessary limitations on personal involvement.

Ethics and law

Students also need to be aware of the ethical dimensions of health care and how these are enshrined in law. From this follows understanding of the importance of communicating effectively in difficult ethical areas. Key ethical considerations include familiarity with (and adherence to) the principles of: confidentiality; consent; beneficence; best interest; autonomy; truth telling; non-maleficence, and justice.

Evidence-based practice

The principles of evidence-based practice require that decisions about health care are based on the best available, current, valid and relevant evidence, and that this should be integrated with clinical expertise and the patient's values and preferences.[28] These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. This applies equally to the following two areas, which are inextricably linked:

- best clinical communication practice, and
- best clinical care practice.

CONCLUSIONS

This document recommends the key content for undergraduate clinical communication curricula. It provides a conceptual model and details the individual components of an effective curriculum. Such a curriculum will facilitate the acquisition of a range of skills and understanding which will enable students to face complex social interactions throughout their medical training and subsequent careers. This document represents the views of UK Council of Clinical Communication Skills Teaching in Undergraduate Medical Education members. We hope that, by setting out a benchmark for clinical communication skills curricula, medical schools will be able to develop the range of learning experiences that all students should encounter in order for them to be sufficiently qualified for a career in medicine.

We also hope that this consensus statement will support the development and integration of teaching, learning and assessment of clinical communication.

Contributors: this paper was developed through an iterative process by the communication skills leads from all 33 UK medical schools conducted under the auspices of the UK Council of Communication Skills Teaching in Undergraduate Medical Education. Following a series of workshops, a small working group, consisting of the authors of this paper, was established to finalise the consensus statement. This was then approved by the UK Council as a whole. All authors contributed to this process.
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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article.

Table S1. The current representatives of the UK Council.

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