

## **Communication Skills**

Communication skills were clearly identified as one of the skill dimensions essential for the competent practice of family medicine. There is a large body of literature on communication and the working group did not attempt to redefine communication or develop a theoretical definition. We chose instead to articulate a pragmatic approach focused on skills and behaviours that facilitate communication.

We began by identifying those themes or skill subsets that are essential to good communication. We then used an interactive focus-group approach to define the themes and observable behaviours that should predict competence for entry to the independent practice of family medicine. Other observable behaviours may be added to this list; however, those identified below should be more than sufficient to determine competence.

These are the themes identified:

1. Listening skills
2. Language skills
  - a) Verbal
  - b) Written
  - c) Charting skills
3. Non-verbal skills
  - a) Expressive
  - b) Receptive
4. Cultural and age appropriateness
5. Attitudinal

The working group felt there were tangible differences between communication with health team members and with patients. Physicians may be able to communicate effectively with one group and not with the other; therefore we chose to separate these areas in our definition. For each group we have identified observable behaviours for each type of interaction. Some behaviours appear in both sections. They have been duplicated in order to be comprehensive.

For each subset of skills we have identified behaviours, expressed either positively (✓) or negatively (✗), that reflect competence. Positive behaviours are listed first, followed by negative behaviours. We have not placed the behaviours in any order of priority. For the most part, only the positive or negative expression of the behaviour was described.

## Effective Communication with Patients

### 1. Listening Skills

Uses both general and active listening skills to facilitate communication

#### Observable Behaviours:

- ✓ Appropriately looks at the patient while the patient is talking
- ✓ Allows the time for appropriate silences
- ✓ Feeds back to the patient what he or she has understood from the patient
- ✓ Provides appropriate non-verbal responses to patient's statements
- ✓ At all times responds to verbal cues (e.g., does not go on with regular questioning when the patient reveals major life or situation changes like "I just lost my mother")
- ✓ Clarifies jargon when used by the patient
- ✓ Comprehends what the patient says
- ✓ Lets the patient tell his or her story (does not interrupt the patient inappropriately)
  
- ✗ Does other things while the patient is talking (e.g., looks at computer chart, takes phone calls)

### 2. Language Skills

#### a) Verbal:

Adequate to be understood by the patient; able to converse at an appropriate level for the patient's age and educational level; appropriate tone for the situation—to ensure good communication and patient comfort

#### Observable Behaviours:

- ✓ Asks open- and closed-ended questions appropriately
- ✓ Checks back with the patient to ensure understanding (e.g., "If I say this, am I understanding you correctly?")
- ✓ Facilitates the patient's story (e.g., "Can you clarify that for me?")
- ✓ Provides clear and organized information in a way the patient understands (e.g., test results, pathophysiology, side effects) and checks back to ensure the patient understands
- ✓ Provides explanations to accompany examinations and/or procedures
- ✓ When first meeting a patient, clarifies how the patient would like to be addressed
  
- ✗ Fails to greet the patient
- ✗ Interrupts patients inappropriately
- ✗ Uses inappropriate word choices for the individual's level of understanding (e.g., use of scientific language that the patient cannot understand, overuse of jargon)
- ✗ Displays inappropriate anger
- ✗ Uses inappropriate humour
- ✗ Uses paternalistic language (e.g., use of "dear")

- ✗ Uses offensive language (e.g., swearing)
- ✗ Shouts or uses excessively loud speech
- ✗ Asks multiple questions without awaiting the answers
- ✗ Has language skills that are insufficient to be easily understood by the majority of patients (i.e., patients can't understand what the physician is saying)

**b) Written:**

Clearly articulates and communicates thoughts in a written fashion (e.g., in a letter to a patient, educational materials for the patient, instructions for a patient)

**Observable Behaviours:**

- ✓ Writes legibly
- ✓ Written material is organized so the patient can understand (spelling, grammar, and punctuation must be sufficient to permit understanding)
- ✓ When providing written information, chooses materials that are appropriate to the patient's level of understanding
  
- ✗ Uses abbreviations that are not understood by the patient

**3. Non-Verbal Skills**

**a) Expressive:**

Being conscious of the impact of body language on communication with the patient and adjusting it appropriately when it inhibits communication

**Observable Behaviours:**

- ✓ Sits while interviewing the patient (in order to convey the feeling of providing the patient with more time and attention)
- ✓ Eye contact is appropriate for the culture and comfort of the patient
- ✓ Is focused on the conversation
- ✓ Adjusts demeanour to be appropriate to the patient's context (e.g., is pleasant, appropriately smiles, is appropriately serious, is attentive, is patient and empathetic)
- ✓ Communicates at eye level (e.g., with children, patients who are bedridden)
- ✓ Physical contact is appropriate for the patient's comfort
  
- ✗ Fidgets
- ✗ Hygiene or dress that inhibit communication
- ✗ Gets too close (not respectful of other's personal space)

**b) Receptive:**

Aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction, anger, guilt)

**Observable Behaviours:**

- ✓ Responds appropriately to the patient's discomfort ( e.g., gets a tissue for a patient crying, shows appropriate empathy with the patient's difficulties )
- ✓ Verbally checks the significance of body language (e.g., "You seem nervous/upset/uncertain/in pain; is that right?")
- ✓ Comments on behaviour/non-verbal actions of the patient when appropriate (e.g., "You seem quiet/unhappy/angry/worried/in pain")
- ✓ Modifies actions during examination or history-taking in response to the patient's discomfort (e.g., adjusts angle of exam table when patients are short of breath during an abdominal exam)
  
- ✗ Misses signs that the patient does not understand what is being said (e.g., blank look, look of astonishment, puzzlement)

**4. Culture and Age Appropriateness**

Adapts communication to the individual patient for reasons such as culture, age, and disability (e.g., the young child or teenager, or someone with speech deficits, hearing deficits, or language difficulties)

**Observable Behaviours:**

- ✓ Uses appropriate communication skills with adolescents (e.g., offers to see them independently, respects the capacity to make decisions, acknowledges issues of confidentiality, specifically directs questions to the adolescent, is not judgmental)
- ✓ Adapts communication style to the patient's disability (e.g., writes for deaf patients)
- ✓ Asks about the need for an interpreter and arranges for one
- ✓ Speaks at a volume appropriate for the patient's hearing
- ✓ Adapts communication style based on the patient's cultural expectations or norms (e.g., other family members in the room)
- ✓ Uses appropriate words for children and teens (e.g., "pee" vs. "void")
  
- ✗ Ignores the patient while exclusively engaging the caregiver, especially with children, the elderly, those with cognitive impairment (e.g., no questions to the patient, patient not involved in management plan)
- ✗ Makes assumptions based on the patient's appearance or dress (i.e., stereotyping the patient)
- ✗ Uses colloquialisms that the patient does not understand

## **5. Attitudinal**

This permeates all levels of communication. This includes the ability to hear, understand, and discuss an opinion, idea, or value that may be different from your own while maintaining respect for the patient's right to decide for himself or herself. Communication conveys respect for the patient.

### **Observable Behaviours:**

- ✓ Shows interest in the patient's opinion
- ✓ Is empathetic
- ✓ Maintains an appropriate attitude in response to inappropriate/offensive language or comments made by the patient
  
- ✗ Appears rude
- ✗ Appears impatient
- ✗ Displays irritation or anger
- ✗ Belittles the patient
- ✗ Trivializes or dismisses the patient's ideas or concerns
- ✗ Is sarcastic
- ✗ Appears intimidating
- ✗ Appears arrogant (e.g., ignores the patient's concerns or opinions about the management plan)

## Effective Communication with Colleagues

(“Colleague”, for our purposes, means all members of the health care team.)

### 1. Listening Skills

Many specific listening skills are better assessed in the context of communication with patients. Some are well assessed in the context of communication with colleagues.

#### Observable Behaviours that Can Be Assessed with Colleagues:

- ✓ Is attentive
- ✓ Stops and takes the time to listen respectfully to colleagues
- ✓ Appropriately maintains eye contact while discussing issues with all members of the health care team
- ✓ Allows sufficient time for colleagues to articulate their concerns
  
- ✗ Does other tasks that interfere with listening

### 2. Language Skills

#### a) Verbal:

Adequate to be understood in face-to-face communication, and with all other commonly used methods (e.g., phone, video conferencing, etc.); adequate to understand complex profession-specific conversation; appropriate for colleagues with different backgrounds, professions, and education; appropriate tone for the situation, to ensure good communication and colleague comfort

#### Observable Behaviours:

- ✓ Introduces self when meeting a colleague for the first time
- ✓ When asking colleagues to do something, makes a clear request and ensures that it is understood
- ✓ Offers rationale for a plan or an approach to improve understanding
- ✓ Adjusts tone to be appropriate to circumstances
- ✓ Asks rather than demands
- ✓ Uses non-blaming, appropriate, and specific observations when addressing difficult circumstances
  
- ✗ Case presentations are poorly organized or incomplete
- ✗ Is not specific with requests
- ✗ Interrupts colleagues
- ✗ Asks multiple questions without awaiting the answers
- ✗ Does not target language to the individual’s professional background and level of understanding
- ✗ Displays inappropriate anger
- ✗ Uses inappropriate humour
- ✗ Uses condescending language
- ✗ Shouts or uses excessively loud speech
- ✗ Swears or uses offensive language

**b) Written:**

(e.g., hospital and office charting, consultant letter, lawyer letter)

- Clearly articulates and communicates thoughts in a written fashion
- Has spelling, grammar, legibility, and punctuation that are adequate to facilitate understanding

**Observable Behaviours:**

- ✓ Writes legibly
- ✓ Written material is organized
- ✓ When writing to request consultation, is specific about questions/reasons and provides relevant information
- ✓ Patient-care plans (e.g., test requests, follow-up orders) are:
  - a) clearly written and
  - b) securely transmitted to the appropriate recipient
- ✗ Uses abbreviations that are not universally known or are prone to misinterpretation

**c) Charting Skills**

Assessment should concentrate mainly on the charting of individual encounters. Overall organization and structure of the ongoing clinical record are important, but these are often predetermined and outside the control of the individual—they can be assessed, but in a different context. Note that these charting skills are formatted as a set of key features.

1. A clinical note must
  - a) be legible.
  - b) avoid using acronyms or abbreviations that may be misunderstood or confusing (e.g., “U” for “units”).
  - c) be organized so as to facilitate reading and understanding.
  - d) follow an agreed-upon structure within a practice setting.
2. Charting must be done in a timely fashion, so as to minimize inaccuracies and lost information, and to ensure that the information is available for others involved in care. It should usually be done immediately after the encounter; if delayed, notes must be made to direct the later charting.
3. Corrections or changes to the note must be clearly visible as such, and dated if not made at the time of the original entry.
4. Should not write anything in the chart that you would not want the patient to read (e.g., disparaging remarks)
5. Must not falsify data (e.g., don’t include data in the note that has not been gathered)

6. The clinical note must
  - a) reflect all the phases of the clinical encounter that are relevant to the presenting situation.
  - b) show an obvious and logical link between the data recorded and the conclusions and plan.
  - c) include the relevant negative findings, as well as the relevant positive findings.
  - d) avoid inappropriate verbatim reporting of the encounter (it should synthesize the data gathered).
7. As part of ongoing care, acknowledge additional received data (e.g., test results, consultation reports) and document follow-up action when appropriate.
8. As new information is gathered during an encounter, maintain the chart according to the expectations of the work milieu (e.g., flow sheets, summary page).
9. Structure and use the clinical record as a tool to try to improve comprehensiveness and continuity of care.

### 3. Non-Verbal Skills

#### a) Expressive:

Appropriate eye contact, respectful of others' personal space, appropriate demeanour (e.g., pleasant, smiles appropriately, appropriately serious, attentive, patient and empathetic), and conscious of the impact of body language on the colleague

#### Observable Behaviours:

- ✓ Is focused on the conversation
- ✓ Eye contact is appropriate for the culture and comfort of the colleague
- ✓ Adjusts demeanour to be appropriate to the colleague's context
- ✓ Physical contact is appropriate for the colleague's comfort

#### b) Receptive:

Aware of and responsive to body language, especially as seen with dissatisfaction; correctly interprets signs of feelings not expressed, such as anger and frustration

#### Observable Behaviours:

- ✓ When a colleague is manifesting signs of distress, demonstrates awareness by actions such as modifying demands, exploring concerns, seeking resolution

### 4. Culture and Age Appropriateness

There may be instances where communication with colleagues and other team members from different cultural backgrounds can be problematic. Awareness of these potential problems and subsequent



adjustments to communication are elements of competence. This, however, is better assessed in the context of communication with patients and in professionalism.

## **5. Attitudinal**

This permeates all levels of communication. Competent family physicians possess an attitude that allows them to respectfully hear, understand, and discuss an opinion, idea, or value that may be different from their own.

### **Observable Behaviours:**

- ✓ Seeks to understand rather than judge
- ✓ Returns the focus to effective patient care when interprofessional conflicts occur
- ✓ Attempts to resolve difficulties before ending the discussion or walking away
- ✓ Apologizes when appropriate
  
- ✗ Appears rude
- ✗ Appears impatient
- ✗ Belittles colleagues or their field of work
- ✗ Trivializes or dismisses ideas or concerns of colleagues
- ✗ Appears arrogant
- ✗ Displays anger or irritation
- ✗ Uses derogatory language when describing a patient's circumstances or case
- ✗ Appears threatening or intimidating