Advancing Education in

Interpersonal and Communication Skills

*An **Educational Resource** from the*

ACGME
Outcome Project

Enhancing residency education through outcomes assessment

ADVANCING EDUCATION IN INTERPERSONAL AND COMMUNICATION SKILLS

OVERVIEW

PURPOSE: To provide educational resources for program directors and other medical educators to teach and assess Interpersonal and Communication Skills, one of the six ACGME general competencies

CONTENT:

Interpersonal and Communication Skills

ACGME Definition

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:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group [1]

Other Perspectives in Interpersonal and Communications Skills

The Macy Initiative in Health Care Communication[2] identified three broad domains of communication skills:

- Communication with the patient
- Communication about the patient
- Communication about medicine and science

The Kalamazoo I Consensus Statement[3] outlined seven essential communication tasks that should be part of communication oriented curricula and evaluation tools:

- Build the doctor-patient relationship
- Open the discussion
- Gather information
- Understand the patient's perspective
- Share information
- Reach agreement on problems and plans
- Provide closure

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[1] Accreditation Council for Graduate Medical Education. ACGME Outcome Project. Retrieved Jun 5, 2005 from www.acgme.org/Outcomes.

[2] Kalet A, Pugnaire M, Cole-Kelly K, Janicik R, Ferrara E, Schwartz M, Lipkin M, Lazare A. Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. Acad Med 2004 79;6:511-520.

[3] Participants in the Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education. Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. Acad Med 2001 76;4:390-393

Frequently Asked Questions about Interpersonal and Communication Skills

How do Interpersonal and Communications Skills affect the physician patient relationship?

- Effective communication enhances patient satisfaction, health outcomes, and adherence to treatment.
- Learning general communication skills enables a physician to break bad news in a way that is less uncomfortable for them and more satisfying for the patient.[4]
- Breakdowns in communication between physician and patient have been shown to be a factor in malpractice litigation. [5]

How can I help my residents see their communication skills still need improvement?

- Oftentimes, communications skills are taught in unstructured workshops and residents may tend to over evaluate their skills. Presenting a structured body of knowledge about communication skills is essential.[6]
- Sometimes, residents may demonstrate lack of self-confidence, particularly in difficult or challenging communication situations and may be reluctant to self-report this. Again, teaching a structured body of knowledge is helpful to them.[7]
- Some residents may equate communications skills with social exchanges with friends and family and not appreciate the impact of their communication style on patients.
- It is essential to be explicit about good and bad models of communicating with patients during precepting.
- Have residents do a self-assessment and compare their view of their skill set to a 360 evaluation or a videotaped encounter.

Can Interpersonal and Communication Skills be changed and improved with instruction?

- Gordon [8]reports there is greater likelihood of a resident improving his/her communication skills if:
    - Evidence based descriptions/demonstrations of skills are used
    - A conceptual model is used
    - Ability to practice skills and receive feedback is present
    - Regular reinforcement by preceptors and application of skills during patient encounters routinely occurs
- Levinson & Rotter (1993) demonstrated that videotaping or audiotaping an interaction and receiving feedback from a standardized patient improved primary care physician's communication skills. [9]

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[4] Rosenbaum M, Ferguson K, Lobas J. Teaching Medical Students and Residents Skills for Delivering Bad News: A Review of Strategies. Acad Med 2004;79:107-117.
[5] Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. Arch Intern Med. 1994; 154:1365-1370.
[6] Fadlon J, Pessach I, Toker A. Teaching medical students what they think they already know. Education for Health 2004; 17:35-41.
[7] Fadlon J, Pessach I, Toker A. Teaching medical students what they think they already know. Education for Health 2004; 17:35-41.
[8] Gordon, B. Assessment of Physician-Patient Communication. Presented at ACGME/ABMS Assessment of Physician Patient Communication Conference. Rosemont, Illinois. March 21-22, 2002.
[9] Levinson W, Roter D. The effects of two continuing medical education programs on communication skills of practicing primary care physicians. J Gen Intern Med. 1993;8:318-324.

Teaching Interpersonal and Communication Skills

** Indicates a more detailed discussion of the curriculum approach follows.

Example	Description
Cinemeducation Alexander M. The Doctor: A Seminal Video for Cinemeducation. Family Medicine 2002; 34:92-4. **	In a small group format, residents view the movie "The Doctor" starring William Hurt and discuss issues such as the psychosocial impact of terminal illness, breaking bad news and stress in a medical marriage.
Model for Medical Interviewing **Standardized Patient and Small Group Discussion** Boyle D, Dwinnell B, Platt F. Invite, Listen, and Summarize: A Patient-Centered Communication Technique. Acad Med 2005; 80:29-32. **	Learners are taught patient-centered interviewing using standardized patients and small group format with role-play. The specific skills addressed include establishing rapport (invite), active listening (listen) and summarizing the patient's story (summarizing). The learners are given feedback on their skills from the standardized patients.
Model for Delivering Bad News **Didactic and Small Group Discussion** Hobgood C, Harward D, Newton K, Davis W. The Educational Intervention "GRIEV-ING" Improves Death Notification Skills of Residents. Academic Emergency Medicine. 2005; 12: 296-301. **	Residents are taught a mnemonic/model for informing families of a death. Residents practice this model via role-play. In addition, residents are encouraged to reflect and share their own experiences. Discussion questions are included at the end of the article. Simulated survivors who provide the resident feedback on their death notification skills then evaluate residents.
Small Group Discussion using Literature and Humanities Sklar D, Doezema D, McLaughlin S, Helitzer D. Teaching Communications and Professionalism through Writing and Humanities: Reflections of Ten Years of Experience. Academic Emergency Medicine. 2002; 9: 1360-1364. **	Senior faculty lead case-based seminars and discussion of assigned readings and writing projects to deepen resident's understanding of communication and professionalism. Residents are given a case with specific trigger questions for discussion. Residents also write about their experiences with patients to deepen their own understanding of issues such as health disparities, medical errors, and access to care. Residents discuss readings including journal articles, novels, and essays by physician writers. Training was provided to senior faculty in problem-based learning and group facilitation to develop skills in small group facilitation. An alternative might be to have social workers or behavioral scientists facilitate this experience.

Using Cinemeducation (Film) To Teach Interpersonal and Communication Skills

Alexander, M. The Doctor: A Seminal Video for Cinemeducation. Family Medicine 2002; 34:92-4.

Goal:
To raise awareness and stimulate reflection and discussion among residents and faculty about such issues as breaking bad news, medical interviewing, and the psychosocial impact of terminal illness

Objectives:
1. Residents will be able to reflect on the importance of physician-patient communication skills
2. Residents will be able to apply good methods of delivering bad news
3. Residents will be able to describe the impact of terminal illness on the patient and the family.

Learning Activity:
Cinemeducation is an excellent way to promote discussion on a wide range of topics in Interpersonal and Communication Skills. This article describes the use of "The Doctor," to teach communication skills such as interviewing, breaking bad news, and the psychosocial impact of terminal illness. Initially, the film is introduced to residents and they are asked to view the video clip. Discussion questions are provided in the article for residents to discuss in a group format. Program Directors also should encourage residents to bring forth their own cases or experiences in order to encourage application of information. Small group or large group discussion format can be used with the following types of questions:

- What are might the physicians have done differently to more successfully deliver the bad news to the patient and his wife?
- How can you be of assistance to patients and their families in facilitating open discussion about serious illness?
- What are challenges faced by physicians in balancing work and home lives?

For a broader list of topics, please see the resource guide Cinemeducation. Ideas for teaching communication skills, specific time counters for the film clips and specific discussion questions are included for a wide range of films and topic areas.

Resource Guide:
Alexander M, Lenahan P, Pavlov A. Cinemeducation. Radcliffe Publishers. Dallas, Texas. 2005.

Using the ILS (Invite-Listen-Summarize) Model to Teach and Assess Patient Centered Communication

Adapted from: Boyle D, Dwinnell B, Platt F. Invite, Listen, and Summarize: A Patient-Centered Communication Technique. Acad Med. 2005; 80:29-32.

Goal:
To improve a resident's communication skills with patients in the ambulatory clinic and inpatient settings.

Learning Objectives:
1. Residents will be able to identify the components of the ILS model
2. Residents will be able to apply the ILS model to interactions with patients

Learning Activity:
The ILS model encourages residents to establish rapport with the patient (Invite), engage in active listening (Listen), and summarize the patient's story throughout the interview (Summarize). These skills are part of a patient-centered interviewing technique that seeks to elicit the patient's perspective. The authors of this model used standardized patients to provide feedback to learners on their ability to apply the model. This is a longitudinal curriculum and scenarios of graded difficulty are used throughout the year. Learners in small groups, working with a standardized patient, are instructed to apply this model to the medical interview. Feedback from peers and standardized patients is used to improve communication skills.

A number of specialties could use this model in a variety of ways, depending on the resources of the program. This model is a more compressed version of the communications model developed by the Kalamazoo Consensus Statement.

Use of Standardized Patients:
Many academic medical centers have standardized patient programs and are happy to help construct specialty specific scenarios that reflect typical communication issues. The model could be presented in a short didactic form followed by resident interaction with a standardized patient who was instructed to give feedback regarding the resident's application of this model. The advantage of this activity is that it provides residents with excellent feedback on their interviewing skills. Standardized patients can also perform formative and summative assessment. Many standardized patient assessment centers have developed scenarios with high reliability and validity.

Role Play:
Role-play is another method that can be used to teach this model. A short didactic could be presented on the model. Ideally, one resident might take the role of the physician while one resident plays the role of the patient. The resident playing the patient could provide feedback to the "physician" on his/her ability to

establish rapport, actively listen, and summarize the “patient’s” story. Residents find it easier to do this activity if cases are chosen beforehand and are relevant to their specialty.

Video/Audio tape:
Videotaping and/or audiotaping allows the resident to self reflect on their communication style with a patient. Faculty review allows for significant discussion and formative feedback designed to improve a resident’s communication skills and enhance the development of an individualized learning plan. Residents and faculty should review the tape with an evaluation tool using behavioral anchors.

Cinemeducation:
A fourth way to teach this model, which is fun for residents, is to present a short didactic on the model. Video clips of popular movies can be used to stimulate discussion about the model and about communication skills in general. For an extensive list of video clips, including discussion items, please see the resource guide section under Cinemeducation. For issues related to copyright, please consult this book as well.

Many of these strategies can be used to teach a variety of topics in Interpersonal and Communications Skills. Please see the bibliography at the end of this booklet for more excellent ideas.

Assessment:
Many of the assessment tools for patient-centered communication skills involve focused observation of the resident interacting with a patient. Program Directors should consider using a focused observation tool about twice a year. A focused observation tool allows faculty to identify a resident’s strengths and weaknesses in patient centered communication and helps residents develop a learning plan for improvement. There are many excellent focused observation tools, such as the Harvard Medical Schools Communication Skills Form or the SEGUE (see assessment section).

Using the Griev-ing Model to Teach and Assess Interpersonal and Communication Skills

Hobgood C, Harward D, Newton K, Davis W. The Educational Intervention "GRIEV-ING" Improves Death Notification Skills of Residents. Academic Emergency Medicine. 2005; 12:296-301.

Goal:
To improve residents ability to notify family members and significant others following the death of a patient

Objectives:
1. Residents will be able to articulate the stages of the "GRIEV-ING" Model
2. Residents will be able to apply this model during various role plays

Learning Activity (2-hour workshop):
1. Short didactic on why death notification is an important skill and the significant verbal and nonverbal characteristics of empathic communication (20 minutes)
2. Small group activity facilitated by program faculty, hospital chaplain or hospital social worker. The focus of this small group activity is to ask residents to share personal experiences about the death of a patient and share communication skills that individuals felt were effective or ineffective for interacting with the family. Discussion questions are included in the appendix to the article.
3. Mini-lecture introducing the GRIEV-ING mnemonic. This mnemonic helps residents remember the appropriate steps to take when notifying family members or significant others about death.
4. Paired role-play – In these role-play residents received and delivered a death notification using the GRIEV-ING mnemonic. They were encouraged to provide helpful feedback to their colleagues
5. Simulated survivor encounter – Residents provided death notification in each of three scenarios portrayed by the simulated survivors. .Residents received feedback on their performance. Example scenarios and checklists for the simulated survivors are included in the article

Assessment:
The assessment for this activity is contained in the simulated survivor feedback and assessment tool included as an appendix to the article.

Comment:
While this model was used within an Emergency Medicine program, it would be equally valuable for other specialties in which notifying families and significant others of a patient's death are required.

Using the Humanities to Teach Interpersonal and Communication Skills and Professionalism

Adapted from: Sklar D, Doezema D, McLaughlin S, Helitzer D. Teaching Communications and Professionalism through Writing and Humanities: Reflections of Ten Years of Experience. Academic Emergency Medicine 2002; 9:1360-1364.

Goal:
To improve resident's interpersonal and communication skills and professionalism

Objectives:

1. Residents will develop a deeper understanding of professional and communication issues.
2. Residents will begin to explore their own feelings regarding their practice of medicine using narratives.

Learning Activity:
The authors describe weekly case based small group discussions focusing on such topics as medical errors, ethical issues, medical malpractice, and racism. Examples of discussion questions are given in the article. Specific readings designed to deepen the reflections of the discussion group are given throughout the year; these include novels, essays, and journal articles by physicians. Residents are also encouraged to write about their experiences with patients. Active participation and discussion by senior faculty help residents reflect on and integrate this experience into their daily activity. Senior faculty were trained in problem based learning and group facilitation through the medical school in order to develop their skills in small group facilitation. As an alternative, behavioral science faculty or social workers might also be helpful in facilitating the discussions.

Assessment:
The authors present a theoretical model for assessment of this curriculum. Currently, they assess this module through required attendance and participation. Interpersonal and communication skills are assessed via a 360 evaluation from physicians, nurses, and patients.

A reflective narrative delineating their experiences and summarizing key individual learning points might be an additional method of assessment. These reflective narratives could become part of the resident's portfolio. The narratives could be assessed by the Program Director using a standard checklist or rubric.

Assessment of Interpersonal and Communications Skills

The RRC Outcome Project Think Tank was an ad hoc advisory group whose purpose was to facilitate implementation of outcomes assessment according to ACGME program requirements. The group was composed of RRC members who were also Program Directors and who recognized the need for practicality and usefulness of assessment tools. Their assessment suggestions for Interpersonal and Communication Skills are based on a literature review of specific competencies, consultation with the ACGME staff and their own practical knowledge of "what works." Please note that multiple measure are recommended for this competency in order to provide the most valid and reliable evidence as to whether the competency has been achieved. The following table summarizes their recommendations.

Outcome Project Think Tank Recommendations:

What to Assess	How to Assess
1. Resident's overall interpersonal and communication skills during a rotation	1. Global performance rating **AND** 2. 360 degree Assessment, to be completed by the resident, professional associates and patients (unless patient care is not the primary activity of the specialty**)**
2. Communication in difficult situations, e.g. breaking bad news, dealing with a non-compliant patient, a frightened patient, or a patient whose ethnicity differs from the resident's ethnicity.	Focused observation and evaluation

Assessment Tools for Interpersonal and Communication Skills

360-Degree (Multi-Source) Assessment Techniques

360-degree (Multi-Source) assessment involves evaluation by individuals in a full circle of reporting relationships. For residents, 360-degree (Multi-Source) assessment might entail evaluation by attendings, other residents, medical students, nurses, ancillary staff, and clerical/administrative support staff. Self-evaluation is an important part of the 360-degree (Multi-Source) assessment.

The 360-degree (Multi-Source) assessment tool from the Urology Resident Evaluation System[10] is provided on the following page. The items were derived from the professionalism and communication skills literature and modified using comments from two physician reviewers. Pilot testing of the instrument is in progress; evaluation of the instrument's reliability and validity will be conducted as a part of the pilot.

Suggestions when using a 360-degree (Multi-Source) Assessment:

- Ask members of the healthcare team (e.g. nurses, technicians, allied health professionals, resident peers) to complete a 360- degree (Multi-Source) evaluation immediately following a rotation in order to capture a current snapshot of the resident's performance.
- Collect 360-degree (Multi-Source) assessment data and give residents aggregate feedback at the biyearly meeting with the Program Director (this helps protect the anonymity of the raters).
- Use an electronic database to manage the information.
- Include a resident self-evaluation to compare the resident's self-perception of their skills with the information from the other 360 evaluators.

Benefits:

- Multiple perspectives on resident abilities can be obtained
- Ratings from multiple evaluators can help increase data validity and reliability
- Residents' ability to accurately self-assess may improve through comparison of self-and other assessments.

Disadvantages:

- A large number of evaluators may be needed before a stable estimate of performance is obtained
- Electronic data systems are needed to ease the difficulty of collecting and aggregating data

Urology 360-Degree Rating Form

Resident: _____ Rotation: _____
Staff: _____ Date: _____

For each item, circle the number that corresponds with how characteristic the behavior is of the resident

PROFESSIONALISM (1-10), INTERPERSONAL & COMMUNICATION SKILLS (11-20)	**Not at all Characteristic**				**Highly Characteristic**	**Don't Know**
1. Follows through on tasks he/she agreed to perform	1	2	3	4	5	DK
2. Responds to requests, including pages, in a helpful and prompt manner	1	2	3	4	5	DK
3. Knows the limits of his/her abilities and asks for help when needed	1	2	3	4	5	DK
4. Takes responsibility for actions, admits mistakes and does not blame others	1	2	3	4	5	DK
5. Makes patient care and well-being a priority	1	2	3	4	5	DK
6. Provides equitable care regardless of patient culture and socioeconomic status	1	2	3	4	5	DK
7. Is willing to act on feedback or other information to improve patient care	1	2	3	4	5	DK
8. Maintains respectful demeanor in demanding and stressful situations	1	2	3	4	5	DK
9. Is honest in interactions with others	1	2	3	4	5	DK
10. Takes on extra responsibilities when the need arises	1	2	3	4	5	DK
11. Easily establishes rapport with patients and their families	1	2	3	4	5	DK
12. Is respectful and considerate in interactions with patients	1	2	3	4	5	DK
13. Responds to patients' needs, feelings, or wishes	1	2	3	4	5	DK
14. Uses non-technical language when explaining and counseling	1	2	3	4	5	DK
15. Spends adequate amount of time with patients	1	2	3	4	5	DK
16. Is willing to answer questions and provide explanations	1	2	3	4	5	DK
17. Is courteous to and considerate of nurses and other staff	1	2	3	4	5	DK
18. Discusses patient issues clearly with staff and faculty	1	2	3	4	5	DK
19. Listens to and considers what others have to say about relevant issues	1	2	3	4	5	DK
20. Maintains complete and legible medical records	1	2	3	4	5	DK

Urology Resident Evaluation System Development Group. Urology Resident Evaluation System http://www.acgme.org/acWebsite/resEvalSystem/reval_360rateForm.pdf. Accessed 6/5/05

Focused Observation Tools

Focused Observation and Evaluation requires direct observation of a resident-patient encounter and concurrent written evaluation. This can occur by having faculty or others observe live or videotaped resident-patient encounters in typical patient care settings followed by assessment and feedback using an instrument developed especially for communication skills. Alternatively, a standardized patient could evaluate the resident and provide feedback. The Segue form and framework has been used by trained observers to assess and direct provision of feedback to over 1000 medical students**.** Segue reliability ranged from .8 -1.0 when raters were trained. Instrument validity was established by face validity, content validity and construct validity. Another tool is The Harvard Medical School Communications Skills Form, which captures the essential elements of communication following the framework set by the Kalamazoo Consensus Statement I. Training faculty raters will increase reliability. This instrument has face, content, and expert validity. Psychometric data is currently being collected.

In order for focused observation to be successful in a program, consider the following key points:

- Train faculty to use the instrument, i.e. to recognize examples of desirable and undesirable communication or involve behavioral scientists as observers.
- Observe resident-patient encounters in settings most representative of where residents provide (and will provide) care to patients, e.g. inpatient wards, ambulatory, or pre-op clinics
- Observe residents early in the educational program to identify skills in need of improvement and again later on to gauge improvement
- Conduct observations involving a range of patients (e.g. resistant, very ill patients, or English as second language patients)

Benefits:

- Communication skill rating forms or checklists direct observer attention to the important skills and qualities
- Improvements can be tracked
- This method facilitates provision of immediate feedback to the resident based on his/her actual behavior (rather than global impressions)
- Use of this method can yield valid and reliable information

Disadvantages:

- Conducting direct observation may be inconvenient or too time consuming for faculty
- Faculty must be trained to use the evaluation tools
- It may be difficult to track improvement unless an electronic system is used

The SEGUE Framework

Patient _____ **Student** _____

Set the Stage

	Yes	No	N/A
1. Greet pt. appropriately			
2. Establish reason for visit: _____			
3. Outline agenda for visit (e.g. "anything else". Issue, sequence			
4. Make personal connection during visit (e.g. go beyond medical issues at hand)			
5. Maintain patient's privacy (e.g. close door)			

Elicit Information

	Yes	No	N/A
6. Elicit pt's view of health problem and/or progress			
7. Explore physical/physiological factors			
8. Explore psychosocial/emotional factors (e.g. living situation, family relations, stress)			
9. Discuss antecedent treatments (e.g. self care, last visit, other medical care)			
10. Discuss how health problems affect pt's life (e.g. quality of life)			
11. Discuss lifestyle issues/prevention strategies (e.g. health risks)			
12. Avoid directive/leading questions			
13. Give pt. opportunity/time to talk (don't interrupt)			
14. Listen. Give patient undivided attention (e.g. face pt, verbal acknowledgement, non verbal feedback)			
15. Check/clarify information (recap; ask "how much is that?")			

Give Information

	Yes	No	N/A
16. Explain rational for diagnostic procedures (e.g. exams, tests)			
17. Teach patient about his/her own body & situation (e.g. provide feedback from exam/tests, explain anatomy/diagnosis)			
18. Encourage pt. to ask questions			
19. Adapt to pt's level of understanding (e.g. avoid/explain jargon)			

Understand the Patient's Perspective

	Yes	No	N/A
20. Acknowledge pt's accomplishments/progress/challenges			
21. Acknowledge waiting time			
22. Express caring, concern, empathy			
23. Maintain a respectful tone			

End the Encounter

	Yes	No	N/A
24. Ask if there is anything else the patient would like to discuss			
25. Review next steps			

Comments:

Visit Date: / / Review Date: / / Reviewer_____

Makoul G. The SEGUE framework for teaching and assessing communication skills. Patient Educ. Couns. 2001; 45(1):23-24.

Harvard Medical School Communication Skills Form*

How well does the student do the following:

A. Builds a Relationship (includes the following):

- Greets and shows interest in patient as a person
- Uses words that show care and concern throughout the interview
- Uses tone, pace, eye contact, and posture that show care and concern
- Responds explicitly to patient's statements about ideas and feelings

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

B. Opens the Discussion (includes the following):

- Allows patient to complete opening statement without interruption
- Asks "Is there anything else?" to elicit full set of concerns
- Explains and/or negotiates an agenda for the visit

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

C. Gathers Information (includes the following):

- Begins with patient's story using open-ended questions (e.g. "tell me about…")
- Clarifies details as necessary with more specific or "yes/no" questions
- Summarizes and gives patient opportunity to correct or add information
- Transitions effectively to additional questions

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

D. Understands the Patient's Perspective (includes the following):

- Asks about life events, circumstances, other people that might affect health
- Elicits patient's beliefs, concerns, and expectations about illness and treatment

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

E. Shares Information (includes the following):

- Assesses patient's understanding of problem and desire for more information
- Explains using words that patient can understand
- Asks if patient has any questions

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

F. Reaches Agreement (IF new/changed plan) (includes the following):

- Includes patient in choices and decisions to the extent s/he desires
- Checks for mutual understanding of diagnostic and/or treatment plans
- Asks about patients ability to follow diagnostic and/or treatment plans
- Identifies additional resources as appropriate

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

G. Provides Closure (includes the following):

- Asks if patient has questions, concerns or other issues
- Summarizes
- Clarifies follow-up or contact arrangements
- Acknowledges patient and closes interview

1 Fair ☐ 2 Fair ☐ 3 Good ☐ 4 Very Good ☐ 5 Excellent ☐

*Adapted from Essential Elements: The Communication Checklist, ©Bayer-Fetzer Group on Physician-Patient Communication in Medical Education, May 2001, and from: The Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education.
Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement. *Academic Medicine* 2001; 76:390-393. ***Contact:*** Elizabeth Rider, MSW, MD--elizabeth_rider@hms.harvard.edu (member, Bayer-Fetzer Kalamazoo Consensus Group).

Interpersonal and Communications Skills

ACGME Web Based Resources

What?	Where?
Example Assessment Tools Additional tools that can be used to assess Interpersonal and Communications Skills	**http://www.acgme.org/outcome/assess/IandC_Index.asp**
RSVP Learn about initiatives underway at various institutions and programs to integrate teaching and assessment of Interpersonal and Communication Skills into the curriculum	**http://www.acgme.org/outcome/implement/impHome.asp**
References Scan references related to theory/concepts/rationale and the teaching and learning of Interpersonal and Communication Skills	**http://www.acgme.org/outcome/assess/refList.asp#ics**
Examples from the field Review short narrative descriptions of how specific assessment techniques are being used by a residency program.	**http://www.acgme.org/outcome/assess/asses_residentPerf.pdf**

Interpersonal and communication Skills

Web based Resource Guide

What?	Where?
American Academy of Physician and Patient The mission of the AAPP is to disseminate the practice of communication in health care relationships	http://www.physicianpatient.org/
Bayer Institute Seeks to improve the communication between clinician and patient	http://www.bayerinstitute.org/
EPERC A centralized, comprehensive resource for end of life physician educators	http://www.eperc.mcw.edu/
Program in Communication and Medicine Enhances communication in and about medicine through innovative teaching and assessment, theory-driven research, and international exchange of information and experience.	http://www.pcm.northwestern.edu/index.htm
Society of Teachers of Family Medicine STFM is dedicated to improving the health of all people through education, research, patient care, and advocacy	http://stfm.org/index_ex.html
The Schwartz Center To support and advance compassionate health care	http://www.theschwartzcenter.org/
Macy Initiative in Health Care Communication An initiative to develop a state of the art, innovative, comprehensive communication skills curriculum grounded in a set of core competencies	http://nyumacy.med.nyu.edu/
AAMC MedEd Portal A centralized repository of educational material	http://www.aamc.org/meded/mededportal/

Additional Bibliography

Reviews on Precepting or Teaching Interpersonal and Communication Skills

Branch W, Kern D, Haidet P, Weissmann, P, Gracey C, Mitchell G, Inui T. Teaching the Human Dimension of Care in Clinical Settings. JAMA *2001*; 9:1067-1074.

Gracey C, Haidet P, Branch W, Weissmann P, Kern D, Mitchell G, Frankel R, Inui T. Precepting Humanism: Strategies for Fostering the Human Dimensions of Care in the Ambulatory Settings. Acad Med 2005; 80:21-28.

Kern D, Branch W, Jackson J, Brady D, Feldman M, Levinson W, Lipkin M. Teaching the Psychosocial Aspects of Care in the Clinical Setting: Practical Recommendations. Acad Med. 2005; 80:8-20.

Mazor K, Simon S, Gurwitz J Communicating with Patient about Medical Errors: A Review of the Literature. Arch Intern Med 164: 1690-1697.

Rosenbaum, M, Ferguson K, Lobas, J Teaching Medical Students and Residents Skills for Delivering Bad News: A Review of Strategies Acad Med 2004; 79: 107-117.