A3. WRITTEN QUESTIONS AND ANSWERS FOR THE COMMUNICATOR ROLE

Created for the *CanMEDS Teaching and Assessment Tools Guide* by J Sherbino and S Glover Takahashi. Reproduced with permission of the Royal College.

See Communicator Role teacher tips appendix for this assessment tool

Instructions for Learner:

Answer questions on your own in time allowed.

You have _____ minutes to answer these questions.

Name: _____

Date: _____

1. Define a minimum of six communication terms from the list below.
   - Categorization
   - Chunking
   - Common ground
   - Difficult discussion
   - Encounter
   - Non-verbal communication skills
   - Paraverbal communication
   - Patient-centred approach
   - Plain language
   - Safety net
   - Shared decision-making
   - Signposting
   - Therapeutic relationships

2. Complete the table below about verbal communication tasks. Identify the sequence, timing, and purposes of each of the communication skills tasks. ***Note: one task has been prefilled as an example.***

No.	Verbal communication skills task	When it takes place in encounter	Purpose(s) (Identify a minimum of two per task)
1.			
2.			
3.			
4.			
5.	Building the relationship	Ongoing	• Developing a therapeutic alliance • Involving the patient
6.			

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A3. WRITTEN QUESTIONS AND ANSWERS FOR THE COMMUNICATOR ROLE (continued)

3. Complete the table below by listing some of the details you would include under each of these three parts of a written communication.

No.	Written communication skills task	Types of details to include
1.	History	
2.	Physician Exam Report (e.g. physical exam, interventions, plan, results)	
3.	Impression and Management	

4. Describe the purpose of a consult letter. List three or four things you would cover in the letter (content). List three style/structure elements that you would incorporate into your letter.

5. Identify three impacts and/or outcomes of effective communication.

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A3. ANSWER KEY SHORT ANSWER QUESTIONS

1. **Define six of these Communicator terms***

- ***Categorization*** is a type of signposting that orients the patient to specific details about how information is going to be discussed. For example, "There are three important things I want to explain. First, I want to tell you what I think is going on; second, what tests I think would be …"
- ***Chunking and checking*** is an approach to giving the patient information in "pieces" then pausing to verify they understand before proceeding. It is a technique used to gauge how much information to give to a patient. This approach aids in achieving a shared understanding with the patient.
- ***Common ground*** provides a basis of mutual interest or agreement
- ***Difficult discussion*** refers to a patient-physician conversation related to the patient's health care preferences, needs, and values that can be challenging because of the high or intense emotion involved. The topics considered challenging or difficult vary on the basis of the patient's preferences, needs, and values; the physician's preferences, needs, values, and comfort level; and the environmental, cultural, and health care contexts.
- ***Empathy*** is a key skill in developing the physician-patient relationship. It has two parts: the understanding and sensitive appreciation of another's predicament or feeling; and the communication of that understanding back to the patient in a supportive way. It does not necessarily equate to agreeing with the patient's feelings. An example is "I can see that your husband's memory loss has been very difficult for you to cope with." Empathy is often confused with sympathy, which is feeling pity or concern from outside of the patient's perspective.
- ***Encounter*** refers to a purposeful patient-physician interaction.
- ***Non-verbal*** communication skills are the skills involved in transmitting information without the use of words. They include body language (e.g. facial expressions, eye contact, gestures), paraverbal skills (e.g. tone, pace, volume of speech), touch, space, smell, and clothing. Non-verbal communication is responsible for conveying most of our attitudes, emotions, and affect. Non-verbal communication can override what we actually say to patients.
- ***Paraverbal*** communication is what you convey in the characteristics of your words through your pace, tone, pitch, rhythm, volume, articulation, and use of pauses.
- ***Patient-centred*** approach is one providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- ***Plain language*** is the use of common words that are understandable by the patient. This may mean avoiding technical or medical terms unless they are carefully defined or described.
- ***Safety net*** means the set of contingency plans for the patient, which should be discussed at the end of the interview. Providing a safety net for the patient involves explaining what the patient should do if things do not go according to plan, telling them how they should contact you, and discussing what developments might require back-up.
- ***Shared decision-making*** is a communication approach where patients and their health care professionals, including their physician, make decisions following careful deliberation about the patient's preferences, needs, and values and with an understanding of the available options and evidence so that they can wisely choose the best action(s).
- ***Signposting*** is the use of bridging statements to alert patients that you are changing topics or direction in the encounter. Signposts help the patient to understand where the interview is going and why. They also help to provide structure to the interview and act as guide markers to keep you organized and patient focused. For example, "I have just finished getting a history of your stomach pain; now I would like to do a physical exam. Is that okay?"
- ***Therapeutic relationship*** is the working alliance between the physician and patient. Respect (i.e. unconditional positive regard), genuineness, and empathy have been correlated with good therapeutic outcomes.

* Refer to Communicator Key Terms in the Tools Guide for full definitions.

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A3. ANSWER KEY SHORT ANSWER QUESTIONS (continued)

2. Complete the table below about verbal communication task. Identify the sequence, timing, and purposes of each of the communication tasks.[a, b]

#	Verbal Communication COMMUNICATION TASK	Timing	PURPOSES (2-4 per task)
1.	INITIATING THE SESSION	Beginning	• Establishing initial rapport • Identifying the reason for the visit
2.	GATHERING INFO AND PHYSICAL EXAM	Middle	• Exploration of the patient problem to discover: • Biomedical perspective (disease) • Patient perspective (illness) • Background information – context
3.	EXPLANATION AND PLANNING	Middle	• Providing the correct type and level of information • Aiding accurate recall and understanding • Achieving a shared understanding – incorporating the patient's perspective • Planning – shared decision-making
4.	CLOSING THE SESSION	End	• Ensuring appropriate point of closure • Forward planning
5.	BUILDING THE RELATIONSHIP	Ongoing	• Developing a therapeutic alliance • Involving the patient
6.	PROVIDING STRUCTURE	Ongoing	• Making organization overt • Attending to flow

3. Complete the table below by listing some of the details you would include under each of these three parts of a written communication.

CONTENT		Sample details
1.	History	• Chief problem/reason for referral • Chief complaint • Relevant past history • Current medications, as appropriate • Other history appropriate to presenting problem: psychosocial history, functional history, family history, review of systems, etc.
2.	Physical Exam	• Physical examination findings relevant to presenting problem
3.	Impression and Management	• Diagnosis and/or differential diagnosis • Management plan • Rationale for the management plan (education) • Report on whether the management plan was discussed with patient • Notes who will be responsible for elements of the management plan and follow-up • Answer the referring physicians question (if present)

a Kurtz SM, Silverman JD. The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes. *Med Educ*. 1996 Mar; 30(2):83-9.

b Silverman J, Kurtz S, Draper J. *Skills for communicating with patients.* 3rd ed. London: Radcliffe Publishing. Copyright © 2013. Reproduced by permission of Taylor & Francis Books UK.

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A3. ANSWER KEY SHORT ANSWER QUESTIONS (continued)

4. Describe the purpose of a consult letter. List three or four things you would cover in the letter (content). List three style/structure elements that you would incorporate into your letter.

Written Communication	PURPOSE	CONTENT	STYLE
CONSULT LETTER	Communicates findings and opinions to the referring physician	**Referring physicians want:** • the consultants impressions (dx and answer to the referring question) • management plan (who will do what and when • medication changes • rationale for recommendations • who is providing ongoing care • guidance and education (articles, advice, guidelines) **Consultants want:** • Record of the history and physical exam • Context that enables the interpretation of investigations • Proof the consultation actually occurred • A clear question	**Language** • Simple language • No abbreviations, acronyms • Short words (less than three syllables) • Active vs. passive voice ("I saw Ms. X …" vs. "Ms. X was seen …" **Visual display** • Organized • Bullet points • Short sentences (one idea per sentence) • Short paragraphs (four to five sentences) • Section headings • Graphics • Right amount of information • Edited (Plan, Dictate, Edit)

5. Identify three impacts/outcomes of effective communications.

#	Impacts/outcomes of effective communications.
1.	Increased accuracy, which improves patient understanding, recall, and compliance and increases efficiency for patients and physicians,
2.	Improved outcomes of care (physiological and psychological),
3.	Heightened perceptions by patients that they are supported by their physicians and improved relationships between patients and caregivers, resulting in higher satisfaction for patients and physicians,
4.	Reduced rates of adverse events/medical errors, and
5.	Better protection against complaints and malpractice claims.

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