The CanMEDS 2015
Communicator Expert Working Group Report

Chair
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The CanMEDS 2015
Expert Working Groups

Since its origins in the 1990s, the CanMEDS Project has been a grand collaborative effort of hundreds if not thousands of educators, Royal College Fellows, family physicians, and other experts. Its development has involved countless hours devoted to literature reviews, stakeholder surveys, focus groups, interviews, consultations, consensus-building, debate, and educational design. As a result, CanMEDS has been heralded worldwide for its utility as a framework to anchor physician competence in the service of patients.

In early 2013, the Royal College, along with key partners, assembled a series of Expert Working Groups (EWGs) organized around the seven core CanMEDS domains. As of January 2014, more than 100 people were involved in updating one or more CanMEDS 2015 subdomains. Each EWG is composed of medical educators and practising physicians from a range of specialties and locations. All participants have contributed their expertise to develop a first draft of the revised framework. Their role is to:

- review the CanMEDS 2005 Framework to identify potential concepts requiring clarification or modification, as well as any gaps or redundancies in the existing CanMEDS competencies
- incorporate new themes such as patient safety and intraprofessionalism into the framework

The Communicator Role review: objectives, principles, and methods

The CanMEDS 2015 Communicator EWG members adopted the following principles as foundational to their work:

- The process is one of revision and renewal: improvement, not reinvention, is the goal.
- The primary target audience is the users of the framework: trainees, front-line teachers, program directors, and Clinician Educators who design programs.
- The constructs of the Communicator Role need to be grounded in theory and best practices, while their presentation should be practical and related to the daily practice of any physician.
- Generic competencies within the Communicator Role should be articulated for all specialties.
- Concepts that are relevant to multiple Roles should be articulated in the Role where they are the most prominent. Although redundancy and overlap
are accepted, and even expected, in practice, the framework itself should avoid repetition while ensuring the appropriate integration of Roles.

Our report was developed by means of the following activities and approaches:

- a review of recent literature (2005–2013)
- a review of the “Emerging Concepts” consultation document
- recruitment of working-group members with wide geographical and discipline-specific (including family medicine) representation and with recognized contributions to, and scholarship in, different aspects of teaching and learning and across the continuum of learning (UME, PGME, and CPD)
- specific recruitment of participants (learners and faculty) as ePanel members, to achieve further breadth in consultation
- integration of recommendations from the eHealth and Patient Safety and Quality Improvement working groups
- review of formal stakeholder consultation (including the CanMEDS 2013 survey and the ICRE 2013 Town Hall)

What's new in the draft 2015 Communicator Role

Major content changes

Scope of the Role. The Communicator EWG faced a significant challenge in establishing and maintaining a clear focus on the scope and context of the CanMEDS Communicator Role. Communication is integral to all of the CanMEDS Roles, and thus the working group made the decision that the Communicator Role should concentrate exclusively on the interaction between physicians and their patients, including patients’ family members and others. * Thus, references to communicating with other professionals have been removed from the suggested revisions for the 2015 framework. In addition, we have recommended that competence in presenting information about a medical issue to the public or media be addressed in the Health Advocate Role. This will appear as a Milestone in Health Advocate in Key Competency 2 in the Series II release later this spring.

An emphasis on patient-centred care. Although the 2005 framework articulated a patient-sensitive approach to communication, shared decision-making, and respect for diversity in the list of elements, the Communicator EWG has decided to emphasize patient-centred and therapeutic communication more explicitly by adopting a definition of patient-centred care summarized for the EWG by one of the EWG members. We felt that patient-centred therapeutic communication is axiomatic to the physician–patient interaction, in which physicians form relationships with patients and their families, so as to facilitate the gathering and sharing of information essential for exemplary health care.

Transfer-of-care issues. The EWG received input from a number of other working groups. The Patient Safety and Quality Improvement Working Group advised consideration of informed consent, informed discharge and handover, delegation of supervision, and disclosure with respect to adverse events and risks. In keeping with our recommendation concerning the scope of the Communicator Role, we felt that handover between health care professionals should be tied to the Collaborator Role; this has been communicated to the Collaborator EWG. Issues of transfers of care, informed consent, and disclosure that we felt were relevant to communication between physicians and patients and their families have been included in this draft competency framework for the Communicator Role either as a competency or milestone.

* Throughout the Series I draft of the CanMEDS 2015 Framework, the phrase “patient and their families” is intended to include all those who are personally significant to the patient and are concerned with his or her care, including, according to the patient’s circumstances, family members, partners, caregivers, legal guardians, and substitute decision-makers.
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**eHealth competencies.** Feedback from the eHealth EWG has been incorporated into the document (in competencies 3 and 4 particularly).

**Increased emphasis on patient education.** When we reviewed the content of key competencies 3 and 4 from the 2005 framework, we saw an opportunity to combine these into one key competency that emphasizes the sharing of information with patients and their families in a way that satisfies a patient-centred philosophy. Included in this revised key competency is an increased emphasis on patient education, a concept previously addressed in 2005 in the Scholar/Teacher Role. Cultural safety as an issue has now been included in key competency 3.

**Disclosure of adverse outcomes.** The Communicator EWG spent considerable time discussing the issue of disclosure of adverse outcomes. We received detailed recommendations on disclosure from the Patient Safety and Quality Improvement EWG. Consideration was given by the Communicator EWG to creating a new key competency, but after considerable debate we decided to create a new enabling competency within key competency 3 to address disclosure.

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**Comparison of 2005 and 2015 frameworks**

**Definition 2005**
As Communicators, physicians effectively facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

**Description 2005**
Physicians enable patient-centered therapeutic communication through shared decision-making and effective dynamic interactions with patients, families, caregivers, other professionals, and important other individuals. The competencies of this Role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care. Poor communication can lead to undesired outcomes, and effective communication is critical for optimal patient outcomes. The application of these communication competencies and the nature of the doctor-patient relationship vary for different specialties and forms of medical practice.

**Definition 2015**
As Communicators, physicians form relationships with patients and their families* that facilitate the gathering and sharing of information essential for exemplary health care.

**Description 2015**
Physicians enable patient-centred therapeutic communication by exploring the patient’s symptoms, which may be suggestive of disease, and by actively listening to the patient’s experience of his or her illness. Physicians explore patients’ fears, their ideas about their illness, the impact of their illness on their lives, and their expectations of their health care and their health care providers. This knowledge will be integrated with an understanding of the patient’s context, including socio-economic status, medical history, family history, stage of life, living situation, work or school setting, and other relevant psychological and social issues. Central to a patient-centred approach is shared decision-making: finding common ground with patients in developing a plan to address their medical problems and health goals in a manner that reflects their needs, values, and preferences. This plan should be informed by evidence and guidelines.

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Because illness affects not only patients but also their families, physicians must be able to communicate effectively with everyone involved in the patient’s care.

### Elements 2005

- Patient-centered approach to communication
- Rapport, trust and ethics in the doctor-patient relationship
- Therapeutic relationships with patients, families and caregivers
- Diverse doctor-patient relationships for different medical practices
- Shared decision-making
- Concordance
- Mutual understanding
- Empathy
- Capacity for compassion, trustworthiness, integrity
- Flexibility in application of skills
- Interactive process
- Relational competence in interactions
- Eliciting and synthesizing information for patient care
- Efficiency
- Accuracy
- Conveying effective oral and written information for patient care
- Effective listening
- Use of expert verbal and non-verbal communication
- Respect for diversity
- Attention to the psychosocial aspects of illness
- Breaking bad news
- Addressing end-of-life issues
- Disclosure of error or adverse events
- Informed consent
- Capacity assessment
- Appropriate documentation
- Public and media communication, where appropriate

### Key concepts 2015

- Accuracy
- Active listening
- Addressing end-of-life issues
- Appropriate documentation
- Attention to the psychosocial aspects of illness
- Breaking bad news
- Capacity assessment
- Concordance of goals and expectations
- Disclosure of adverse events
- Diverse physician–patient relationships for different medical practices
- Effective oral and written information for patient care across different forms of media
- Efficiency
- Eliciting and synthesizing information for patient care
- Empathy
- Ethics in the physician–patient relationship
- Expert verbal and non-verbal communication
- Informed consent
- Mutual understanding
- Patient-centred approach to communication
- Privacy and confidentiality
- Rapport
- Relational competence in interactions
- Respect for diversity
- Shared decision-making
- Therapeutic relationships with patients and their families
- Transition in care
- Trust in the physician–patient relationship
Key competencies 2005

Physicians are able to…

1. Develop rapport, trust and ethical therapeutic relationships with patients and families;
2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues and other professionals;
3. Accurately convey relevant information and explanations to patients and families, colleagues and other professionals;
4. Develop a common understanding on issues, problems and plans with patients and families, colleagues and other professionals to develop a shared plan of care;
5. Convey effective oral and written information about a medical encounter.

Enabling competencies 2005

Physicians are able to...

1. Develop rapport, trust, and ethical therapeutic relationships with patients and families
1.1. Recognize that being a good communicator is a core clinical skill for physicians, and that effective physician-patient communication can foster patient satisfaction, physician satisfaction, adherence and improved clinical outcomes
1.2. Establish positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty and empathy
1.3. Respect patient confidentiality, privacy and autonomy
1.4. Listen effectively
1.5. Be aware and responsive to nonverbal cues
1.6. Effectively facilitate a structured clinical encounter

Key competencies 2015

Physicians are able to …

1. Establish professional therapeutic relationships with patients and their families
2. Elicit and synthesize accurate and relevant information along with the perspectives of patients and their families
3. Engage patients and others in developing plans that reflect the patient’s health care needs and goals
4. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy

Enabling competencies 2015

Physicians are able to ...

1 Establish professional therapeutic relationships with patients and their families
1.1 Communicate using a patient-centred approach that encourages patient trust and autonomy and is characterized by empathy and respect
1.2 Optimize the physical environment for patient comfort, dignity, privacy, engagement, and safety
1.3 Recognize when the values, biases, or perspectives of patients, physicians, or other health care providers may affect the quality of care, and modify the approach to the patient appropriately
1.4 Respond appropriately to patients’ non-verbal communication and utilize appropriate non-verbal behaviours to enhance communication with patients
1.5 Manage emotionally charged conversations and conflicts
1.6 Adapt to the unique needs and preferences of each patient and to his or her clinical condition and circumstances
2. Accurately elicit and synthesize relevant information and perspectives of patients and families, colleagues, and other professionals

2.1. Gather information about a disease, but also about a patient’s beliefs, concerns, expectations and illness experience

2.2. Seek out and synthesize relevant information from other sources, such as a patient’s family, caregivers and other professionals

3. Accurately convey relevant information and explanations to patients and families, colleagues and other professionals

3.1. Deliver information to a patient and family, colleagues and other professionals in a humane manner and in such a way that it is understandable, encourages discussion and participation in decision-making

4. Develop a common understanding on issues, problems and plans with patients, families, and other professionals to develop a shared plan of care

4.1. Effectively identify and explore problems to be addressed from a patient encounter, including the patient’s context, responses, concerns, and preferences

4.2. Respect diversity and difference, including but not limited to the impact of gender, religion and cultural beliefs on decision-making

4.3. Encourage discussion, questions, and interaction in the encounter

4.4. Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care

4.5. Effectively address challenging communication issues such as obtaining informed consent, delivering bad news, and addressing anger, confusion and misunderstanding

2 Elicit and synthesize accurate and relevant information along with the perspectives of patients and their families

2.1. Use patient-centred interviewing skills to effectively identify and gather relevant biomedical information

2.2. Manage the flow of a physician–patient encounter

2.3. Inquire about and explore the patient’s beliefs, values, preferences, context, expectations, and health care goals

2.4. Seek out and synthesize relevant information from other sources, including the patient’s family, with the patient’s consent

3 Engage patients and others in developing plans that reflect the patient’s health care needs and goals

3.1. Provide explanations that are clear, accurate, and adapted to the patient’s level of understanding and need

3.2. Share information that is timely, accurate, and transparent in regard to the patient’s health status, care, and outcome

3.3. Engage patients in a way that is respectful, non-judgmental, and ensures cultural safety

3.4. Assist patients and others to identify and make use of information and communication technologies to support their care and manage their health

3.5. Use counselling skills and decision aids to help patients make informed choices regarding their health care

3.6. Disclose adverse events to patients and/or their families accurately and appropriately
5. Convey effective oral and written information about a medical encounter

5.1. Maintain clear, accurate, and appropriate records (e.g., written or electronic) of clinical encounters and plans

5.2. Effectively present verbal reports of clinical encounters and plans

5.3. When appropriate, effectively present medical information to the public or media about a medical issue

4  Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy

4.1 Document clinical encounters in an accurate, complete, timely, and accessible manner, in compliance with legal and regulatory requirements

4.2 Communicate effectively using an electronic health record or other digital technology

4.3 Share information with patients and appropriate others in a manner that respects patient privacy and confidentiality