

Essential Elements of Communication in Medical Encounters: The Kalamazoo Consensus Statement

Participants in the Bayer–Fetzer Conference on Physician–Patient Communication in Medical Education

ABSTRACT

In May 1999, 21 leaders and representatives from major medical education and professional organizations attended an invitational conference jointly sponsored by the Bayer Institute for Health Care Communication and the Fetzer Institute. The participants focused on delineating a coherent set of essential elements in physician–patient communication to: (1) facilitate the development, implementation, and evaluation of communication-oriented curricula in medical education and (2) inform the development of specific standards in this domain. Since the group included architects and representatives of five currently used models of doctor–patient communication, participants agreed that the goals might best be achieved through review and synthesis of the models. Presentations about the five models encompassed their research base, overarching views of the medical encounter, and current applications. All attendees

participated in discussion of the models and common elements. Written proceedings generated during the conference were posted on an electronic listserv for review and comment by the entire group. A three-person writing committee synthesized suggestions, resolved questions, and posted a succession of drafts on a listserv. The current document was circulated to the entire group for final approval before it was submitted for publication. The group identified seven essential sets of communication tasks: (1) build the doctor–patient relationship; (2) open the discussion; (3) gather information; (4) understand the patient’s perspective; (5) share information; (6) reach agreement on problems and plans; and (7) provide closure. These broadly supported elements provide a useful framework for communication-oriented curricula and standards. *Acad. Med.* 2001;76:390–393.

A growing emphasis on physician–patient communication in medicine and medical education is reflected in international consensus statements,^{1,2} guidelines for medical schools,^{3–6} and standards for professional practice and education.^{7–12} In May 1999, with work in these areas and related research^{13–17} as a backdrop, 21 people from medical schools, residency programs, continuing medical education providers, and prominent medical educational organizations in North America convened for three

days in Kalamazoo, Michigan, for the Bayer–Fetzer Conference on Physician–Patient Communication in Medical Education. The aim of this invitational conference was to identify and specifically articulate ways to facilitate communication teaching, assessment, and evaluation.

The group used an open-ended, iterative process to identify and prioritize topics for discussion. A major topic of interest to the entire group was delineating a set of essential elements in physician–patient communication. Participants expressed three goals for the discussion:

1. Reaching consensus on a “short list” of elements that would characterize effective communication in several clinical contexts.

2. Providing tangible examples of skill competencies that would be useful for licensing bodies, organizations that accredit medical schools and residency programs, and directors of medical education programs at all levels.

3. Ensuring that the product generated by the group would be evidence based and appropriate for teaching, assessment, and evaluation.

Since the group included architects and representatives of five currently used models of doctor–patient communication, participants agreed that the goals might best be achieved through review and synthesis of the models’ essential elements. Toward that end, brief presentations were delivered about each of the five models:

The conference participants are listed in a box at the end of the text.

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- Bayer Institute for Health Care Communication E4 Model¹⁸
- Three Function Model/Brown Interview Checklist¹⁹
- The Calgary–Cambridge Observation Guide²⁰
- Patient-centered clinical method²¹
- SEGUE Framework for teaching and assessing communication skills²²

Each presentation included an explicit description of the model, encompassing its research base, overarching views of the medical encounter, and current applications. After discussion of the models, attendees from the Accreditation Council for Graduate Medical Education (ACGME), the CanMEDS 2000 Project, the Educational Commission for Foreign Medical Graduates (ECFMG), and the Macy Health Communication Initiative provided information about their efforts to develop criteria for teaching and evaluating physician–patient communication. The group then began looking for commonalities among the models as well as points of departure. This process was enriched by the number and diversity of organizations represented by conference participants.

THE ESSENTIAL ELEMENTS

Consensus on the essential elements of physician–patient communication was reached by using the three goals outlined above to guide and ground discussion. The group’s perspective on essential elements is consistent with the task approach, a concept that has been well supported in communication skills teaching since the early 1980s.^{3,18–25} As noted by Makoul and Schofield,² “focusing on tasks provides a sense of purpose for learning communication skills. The task approach also preserves the individuality of [learners] by encouraging them to develop a repertoire of strategies and skills, and respond to patients in a flexible way.”

By identifying specific communication tasks, the group worked to highlight behaviors that are embedded in existing consensus statements, guide-

lines, and standards. While the list is by no means exhaustive, the intent was to make it easier for people working in this area to identify not only the key tasks, but the relevant knowledge, skills, and attitudes as well. References for the supporting research are listed and discussed in a number of texts.^{20,21,23–28}

Build a Relationship: The Fundamental Communication Task

A strong, therapeutic, and effective relationship is the sine qua non of physician–patient communication.^{29,30} The group endorses a patient-centered, or relationship-centered, approach to care, which emphasizes both the patient’s disease and his or her illness experience.^{31,32} This requires eliciting the patient’s story of illness while guiding the interview through a process of diagnostic reasoning. It also requires an awareness that the ideas, feelings, and values of both the patient and the physician influence the relationship.^{2,15,33} Further, this approach regards the physician–patient relationship as a partnership, and respects patients’ active participation in decision making.^{34–36} The task of building a relationship is also relevant for work with patients’ families and support networks. In essence, building a relationship is an ongoing task within and across encounters: it undergirds the more sequentially ordered sets of tasks identified below.

Open the Discussion

- Allow the patient to complete his or her opening statement
- Elicit the patient’s full set of concerns
- Establish/maintain a personal connection

Gather Information

- Use open-ended and closed-ended questions appropriately
- Structure, clarify, and summarize information
- Actively listen using nonverbal (e.g., eye contact) and verbal (e.g., words of encouragement) techniques

Understand the Patient’s Perspective

- Explore contextual factors (e.g., family, culture, gender, age, socioeconomic status, spirituality)
- Explore beliefs, concerns, and expectations about health and illness
- Acknowledge and respond to the patient’s ideas, feelings, and values

Share Information

- Use language the patient can understand
- Check for understanding
- Encourage questions

Reach Agreement on Problems and Plans

- Encourage the patient to participate in decisions to the extent he or she desires
- Check the patient’s willingness and ability to follow the plan
- Identify and enlist resources and supports

Provide Closure

- Ask whether the patient has other issues or concerns
- Summarize and affirm agreement with the plan of action
- Discuss follow-up (e.g., next visit, plan for unexpected outcomes)

CONCLUSION

This outline of essential elements in effective physician–patient communication provides a coherent framework for teaching and assessing communication skills, determining relevant knowledge and attitudes, and evaluating educational programs. In addition, the outline can inform the development of specific standards in this domain. Most of the elements included in this document are present in each of the five models examined during the process of consensus building. A major strength of the outline is that it represents the collaboration and consensus of individuals with a variety of backgrounds and in-

terests in medical education. Further, the basic outline can be tailored to meet the needs of different specialties, settings, and health problems. Conscientious efforts to address these essential elements across practice settings will help increase the efficiency and effectiveness of physician-patient communication,³⁷ enhance patient and physician satisfaction,^{38,39} and improve health outcomes.⁴⁰

Gregory Makoul, PhD, director of the Program in Communication and Medicine at Northwestern University Medical School, provided leadership in the writing process.

The Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education was held May 11-14, 1999. The Bayer Institute for Health Care Communication is a non-commercial, nonprofit, organization whose mission is to improve health through education, research, and advocacy in the area of clinician-patient communication. The Fetzer Institute is a nonprofit, private operating foundation that supports research, education, and service programs exploring the integral relationships among body, mind, and spirit. The conference site was Seasons, A Center for Renewal, owned and operated by the Fetzer Institute, in Kalamazoo, Michigan.

This consensus statement reflects the views of the conference participants; it does not necessarily imply endorsement by their institutions or associations.

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