Assessing Interpersonal and Communication Skills

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Interpersonal and communication skills (ICS) are at the heart of every health care relationship. These verbal and nonverbal skills allow us to elicit and convey important information. In the day-to-day practice of medicine, good communication fosters effective patient care, builds trust, establishes rapport, develops teamwork, and leads to successful patient outcomes and optimal therapeutic relationships. Poor communication leads to mistrust, inefficiency, increased costs, and potentially higher morbidity and mortality.[1–3] Physicians with poor communication skills are more likely to be sued—as many as 30% of medical lawsuits stem directly from a failure to communicate.[4] While natural empathy and winsome personalities facilitate rapport and likeability, they are not substitutes for effective, clear communication. Good ICS skills are learned behaviors that can be broken down into component elements with demonstrable assessment of progress.[5]

Interpersonal and communication skills are one of the 6 core competencies identified by the Accreditation Council for Graduate Medical Education (ACGME). In Milestones 2.0, ICS is subdivided into 3 categories delineating widening circles: patient and family-centered communication, interprofessional and team communication, and communication within health care systems. This article focuses on ICS assessment of both verbal and nonverbal communication with patients/family and the health care team. While not a comprehensive review of the subject, this summary can be used as a platform from which deeper dives into specific methodology can occur depending on the needs and resources of a particular program or setting. Program directors are encouraged to engage with their national program directors' associations to collaborate on specialty-specific best practices for ICS assessment.

Assessment Methods

There are various methods available to assess trainees' ICS, each with benefits and drawbacks as summarized in the TABLE. In direct observation, a faculty member and/or communication expert watches the interaction between the trainee and a second individual. Assessors may use various instruments to provide ratings on verbal skills (eg, asking open-ended questions, making empathic statements, checking for understanding) and non-verbal skills (eg, open body language, eye contact, and balancing use of the electronic health record). Some skills are context specific, such as the presence of a clear action plan with anticipatory guidance during a patient handoff (team communication) or giving a warning shot when breaking bad news (patient/family communication). Feedback can also be obtained directly from the person receiving the communication. Finally, feedback to the learner should always be a part of assessing ICS.[6–8]

Objective structured clinical examinations with standardized patients may be used to assess a trainee's ICS skills with patients and families. This approach can be especially useful if one wants to prepare trainees for more challenging patient interactions (eg, hostile, overly anxious or uncommunicative patients). Interactions can be filmed for review so trainees can see their own behavior.[9,10] While standardized patients decrease variability given the nature of the encounter, they lack the benefit of the complexity of the authentic clinical environment.

Multisource, or 360-degree, feedback is another modality to assess ICS and is especially useful in evaluating interprofessional teamwork and capturing the patient's/caregiver's perspective. Multisource feedback also allows trainees to assess their own performance and calibrate their self-perception as compared to the perception of others using the same measurement scale.[11–14] The ACGME has released the Teamwork Evaluation Assessment Module (TEAM), an open access multisource feedback tool that focuses on interprofessional communication and teamwork skills.[15] The National Board of Medical Examiners also provides several tools. The Assessment of Professional Behaviors program that is housed in MedEdPORTAL includes ICS assessment instruments, implementation guidance, sample feedback reports, and training modules for raters and feedback facilitators.[16] The second tool, developed in conjunction with organizations in the Interprofessional Professionalism

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TABLE
Assessment Methods

Method	Pros	Cons	Feedback Source
Direct observation (sole source)[6,7,9,17–20]	▪ Individualized feedback ▪ Versatile as to setting (simulation vs real life) and skill being assessed ▪ Can teach observer the skills necessary to do this well	▪ Most reliable with validated instrument ▪ Subject to the opinion of the observer so works best with trained observer	▪ Standardized patient ▪ Live patient ▪ Observed structured clinical examination
Direct observation (multisource)[9–11,13,21]	▪ Individualized feedback ▪ Versatile as to setting (simulation vs real life) and skill being assessed	▪ Subject to the biases of the observer as often the observers have not undergone formal training and lack specific skills	▪ Standardized patient ▪ Live patient ▪ Observed structured clinical examination
Team assessment[12,22–24]	▪ Team feedback ▪ Team building ▪ Works with simulated and real-life scenarios	▪ Unique to the composition of that team ▪ Can be subject to the power dynamics of the team hierarchy	▪ Team members ▪ Direct observers ▪ Formal debriefing session
Recording of interaction[9,10,17]	▪ Allows trainee to see themselves	▪ Added pressure of recording process may alter behavior	▪ Standardized patient ▪ Live patient ▪ Observed structured clinical examination

Collaborative, is the Interprofessional Professionalism Assessment (IPA), which contains 26 items of observable behaviors including communication. An online tool kit is available to teach interprofessional professionalism, which includes the IPA instrument, case scenario videos, an on-demand webinar, and related materials.[22,23]

Patient feedback regarding a trainee's interpersonal and communication skills is paramount, as only the patient can truly determine if the communication was effective. Patient feedback obtained through these approaches is an example of "clinimetrics." Clinimetrics refers to "the assessment of clinical and personal phenomena of importance to patient care, through the application of quantitative measures such as indices, scales, and inventories. The aim of clinimetrics is to ensure the human and clinical relevance of a measurement system, as well as its scientific quality."[25] Essentially, clinimetrics aims to establish validated, meaningful instruments to capture the patient experience and find ways to improve it.[25] Several clinimetric instruments used to assess practicing physicians can also be used to assess trainees, including a suite of Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Press Ganey surveys. However, not all instruments focus on a sole provider, and some surveys may attribute the entire visit to the attending physician even though multiple clinical providers and nonclinical support staff influence the evaluation. Alternatively, patients can be asked open-ended questions regarding ICS-related skills.[26] Utilizing the TRICARE Inpatient Satisfaction Survey, exit interviews with a nurse or medical assistant at the end of a clinical encounter, or other similar means are ways to procure patient feedback.

Despite the importance of obtaining the patient voice in the assessment of trainees' ICS, there are numerous logistical challenges to capturing these data. Research has shown that 45 patients must complete an assessment to obtain a highly reliable estimate (ie, reliability coefficient > than 0.8) of a provider's skill set. However, it may be difficult to obtain this number of surveys for trainees, even in the setting of a continuity clinic spanning several years.[27,28] Patients may not want to spend extra time doing this; they may be unfamiliar with electronic survey platforms; they may not be able to complete assessments secondary to language or cognitive barriers; or their perception of the physician's skill may be clouded by cultural influences.[29–31] Lower numbers of patient surveys are still important, however, for formative assessment purposes.

Implementation Strategies

As programs move forward in the assessment of ICS, it is important to appraise the training program's ICS curriculum (both explicit and implicit). Multiple educational strategies and tools are available to teach these skills, and whenever possible, active learning

should be prioritized.[17,18] Examples include videos demonstrating skilled versus unskilled interactions, role-playing, and simulations using standardized patients. In graduate medical education, learning often takes place in the context of patient care. Therefore, debriefing after direct observation of a clinical encounter and providing learners with specific, behaviorally focused actionable feedback is essential.

Despite the barriers that exist in assessing ICS of trainees, there are strategies that overcome these problems. Faculty development to enhance assessors' own interpersonal and communication approaches and their ability to assess these skills in trainees is essential. Faculty with effective ICS are better prepared to model behaviors for trainees, make better assessments of trainees, and offer specific, behaviorally based suggestions for improvement. Faculty should also be trained on writing robust narrative comments to complement numerical or other defined ratings in all assessment settings.[32] Defined scales allow objective measurement of progress, but raters' open-ended observations enable a fuller picture of the trainee's strengths and opportunities for improvement to emerge. Program funds should support ICS development by covering the cost of faculty training and the use of standardized patients and simulation.

Finally, implementation strategies must also focus on the learners themselves. Programs must emphasize that ICS is an essential core competency that can be further developed during training. Programs should explicitly highlight how these skills will be taught and how learners can expect to receive feedback about them. Programs need to create a culture in which seeking out assessment in ICS is safe and encouraged. In addition, learners must be continuously supported in improving ICS as part of their self-regulated learning and professional development. Trainees also must be objective and honest in considering their own performance and make a concerted effort to learn ICS skills. Faculty assessing trainees should learn how to facilitate self-awareness from the learner since external assessments are unlikely to be as effective as learners' self-discovery.[33]

Conclusions

Outstanding ICS is the vital link that transforms medical knowledge into effective patient care. Medical educators must make a concerted effort to highlight the crucial importance of ICS and involve collaboration between programs, teachers, patients, the care team, and trainees.[34–38] The ultimate goal of ICS trainee education is to provide a robust, evidence-based approach to training and learning so that physicians effectively interact with patients and the health care team to achieve better health care outcomes.

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