

## Medical Education

## A European consensus on learning objectives for a core communication curriculum in health care professions

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## ABSTRACT

**Objective:** To develop learning objectives for a core communication curriculum for all health care professions and to survey the acceptability and suitability of the curriculum for undergraduate European health care education.

**Methods:** Learning objectives for a Health Professions Core Communication Curriculum (HPCCC) in undergraduate education were developed based on international literature and expert knowledge by an international group of communication experts representing different health care professions. A Delphi process technique was used to gather feedback and to provide a consensus from various health care disciplines within Europe.

**Results:** 121 communication experts from 15 professional fields and 16 European countries participated in the consensus process. The overall acceptance of the core communication curriculum was high. 61 core communication objectives were rated on a five-point scale and found to be relevant for undergraduate education in health care professions. A thematic analysis revealed the benefits of the HPCCC.

**Conclusions and practice implications:** Based on a broad European expert consensus, the Health Professions Core Communication Curriculum can be used as a guide for teaching communication inter- and multi-professionally in undergraduate education in health care. It can serve for curriculum development and support the goals of the Bologna process.

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## 1. Introduction

Communication in health care has become a major topic in the past few decades [1,2] and the impact of providers' communication competencies on patients' clinical outcomes and communication

in medical teams have been a significant area of focus [3–6]. Research has consistently demonstrated clear links between effective clinical communication and patient satisfaction, adherence, recall, symptom relief and physiological outcomes of care [7–11]. Although comprehensive approaches to teaching communication skills within medical education and a number of consensus statements, frameworks and models already exist [12–21], most of these have been focused on training single provider groups, namely physicians.

Outside of medical education, only a few examples exist of published systematic approaches to communication skills training

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in other healthcare professional groups [22–25]. Communication training in undergraduate education within non-medical health-care professions is less well developed and has been hampered by the lack of available resources for both research and training. The provision of common learning objectives in communication for health care professionals across disciplines is still rare [26,27] despite considerable overlap in the core communication process skills used in different professional groups. This is an issue both for inter-professional approaches to education (more than one provider group learning together) and multi-professional approaches (having a common educational approach across different provider groups taught separately from each other). This is despite the importance of the Bologna declaration [28] for many health care professions within Europe. The Bologna process aims to restructure European higher education ensuring comparability and compatibility of academic education and degrees, and to provide more flexibility among different academic fields, encouraging more inter-professionalism in European education. A core communication curriculum applicable in all health care professions throughout Europe, which defines common inter-professional objectives in communication for undergraduate/pre-registration teaching and is based on a broad European consensus, can be a first step to improve the current situation.

To develop a core communication curriculum for all health care professions, expertise from many European countries and different health care professions is needed. The European Association for Communication in Health Care (EACH) has established the subcommittee “tEACH” to support the development of communication teaching throughout Europe. In 2008, the committee established a work-group with 46 experts from 18 European countries. All participants are involved in curricular development, teaching, assessing communication skills and/or train-the-trainers programs. The different health care professions represented in the group include medicine, midwifery, nursing, pharmacy, psychology, dentistry and physiotherapy. The “core communication curriculum subgroup” of tEACH, has taken the challenge to develop and achieve consensus on a Health Professions Core Communication Curriculum (HPCCC) to be used for undergraduate education in Europe.

## 2. Methods

To develop the HPCCC and to achieve a European consensus, a systematic academic approach and the Delphi technique were used [29–31]. The process of the curriculum development was split in 4 phases within the process: (1) development of a first draft by 10 tEACH subgroup experts on basis of literature [12–20,32–57], and expert knowledge within the subgroup; (2) first Delphi round with 24 communication experts from 14 European countries within tEACH in order to give recommendations for revising the first draft; (3) second Delphi round with 27 tEACH experts from 15 countries to test the revised draft and make suggestions for improvement (4) a final Delphi round for the European consensus with 84 European communication experts outside of tEACH from 16 countries coming from 15 professional health care fields rating the draft.

Curriculum development and the Delphi process in detail (Fig. 1):

### 1. Expert information exchange and literature review:

Development of the first draft was achieved through review of existing literature and extensive discussion by 10 tEACH members from 8 countries representing 7 different health care professions. Our methodological approach was to develop initial objectives drawing on existing consensus statements, frameworks and guidelines. These statements are based on evidence

and expert knowledge and they have a broad acceptance among communication professionals. When we could not find consensus statements in non-medical professions we then included articles reflecting the teaching of communication skills and curriculum development for various professional groups in various languages and countries in order not to miss relevant aspects. These articles were published in English, German, Romanian, Spanish, Polish and Portuguese [31–56].

The consensus statements and relevant frameworks were analyzed under three major categories: 1) ‘key communication tasks’ focusing on relationship building and information exchange with patients; 2) ‘recommended skills’ focusing on observable skills and communication techniques; 3) ‘special communication tasks’ focusing on challenging situations and team communication (Table 1).

Based on this analysis, we decided to use the Basel Consensus Statement [16] as the basis for the first draft of the HPCCC. There were several reasons for using the Basel consensus. These include that among the available taxonomies, the Basel Consensus was one of the most comprehensive in inclusion and detailed description of objectives and that objectives were defined according to Bloom’s taxonomy using a skills based approach. Because the Basel Consensus focuses on social as well as communication competencies, we removed those objectives highly related to social competencies as they were outside the purpose of HPCCC. Remaining objectives were then modified to cover additional aspects revealed in the literature review and to make the objectives more suitable for inter- and multi-professional needs. The first draft contained 100 objectives to be achieved by the end of undergraduate/pre-registration education in health care professions.

### 2. Delphi process

**First Delphi round:** The first draft was inter-professionally reviewed by 24 communication experts within tEACH in order to assess inter- and multi-professional relevance, importance and applicability of the different objectives. This first Delphi round within the tEACH group led to a revision of the first draft. Aspects deemed unimportant in that they had a lower than 60% acceptance rate were eliminated. Ambiguous aspects were reworded and new aspects incorporated (i.e. inter-cultural or gender communication). The emerging second version resulted in 66 learning objectives.

**Second Delphi round:** All members of tEACH apart from the ‘core curriculum group’ ( $n = 36$ ) were invited to rank the 66 objectives in the second draft using a ranking from 1 to 5 (1: most important, 2: very important, 3: important, 4: rather unimportant and 5: unimportant). 27 tEACH members responded leading to the exclusion of 5 objectives resulting in a final draft containing 61 learning objectives covering three main topics: 1) communication with patients (34 objectives); 2) intra- and interpersonal communication (12 objectives) and 3) communication in health care teams (15 objectives). Learning objectives were grouped under subheadings: where learning objectives could fit under more than one subheading, they were allocated to a single place within the document, with the intention that future users of the document could be flexible about groupings. Delineation of core communication objectives that could apply to any clinical interaction were followed by more detailed specific objectives, applicable depending on different contexts and tasks.

**Third Delphi round:** The final draft was sent out to European communication experts outside of tEACH who had experience in teaching, assessing and/or curricular development in communication for health professionals. tEACH members contacted up to ten communication experts from different health care

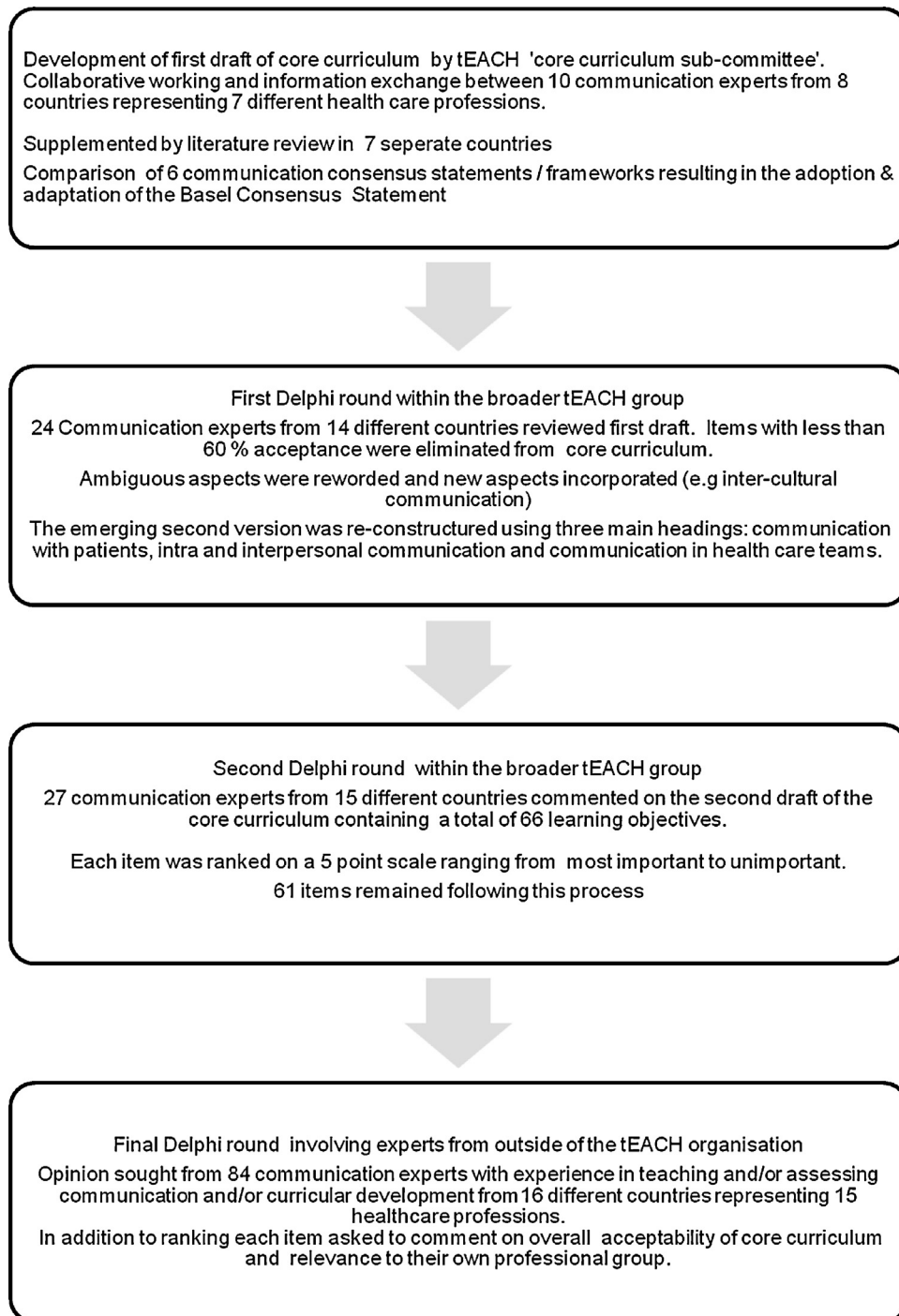


Fig. 1. Development of core curriculum and Delphi process.

professions in their countries with the request that they rank the 61 objectives with regard to importance on a 5-point-Likert-scale (1: most important, 2: very important, 3: important, 4: rather unimportant and 5: unimportant). The experts were also asked to comment on the HPCCC as a whole and the usability of the curriculum within their own professional field. In addition, experts described their experience in teaching, assessing and/or developing curricula in communication in their professional field.

### 3. Data analysis

Data from the final Delphi round was entered into an SPSS-database. Analysis was undertaken by nine members of the

'tEACH core communication curriculum subgroup'. Quantitative analysis is based on descriptive analysis, parametric and non-parametric tests, such as Mann–Whitney *U*. Impact of importance on each objective was measured in means and medians, the acceptance of each objective was calculated on basis of the percentage of consensus experts who rated the objective as "most important", "very important" or "important". Qualitative analysis using a thematic approach identified the salient themes in participants' comments regarding the overall HPCCC and applicability to their own profession. Comments in each category were reviewed by four members of the 'core communication curriculum subgroup' to identify initial themes

**Table 1**  
Comparison of consensus statements/frameworks.

	Toronto	Kalamazoo	UK	Basel	CanMEDS	MAAS
<b>Key Tasks</b>						
Build relationship, developing trust & rapport		✓	✓	✓	✓	
Elicit information from the patient/Problems and concerns	✓	✓	✓	✓	✓	✓
Consider the patients perspective of the illness	✓	✓	✓	✓	✓	✓
Give relevant information and explanations	✓	✓	✓	✓	✓	✓
Develop shared plan of care	✓	✓	(✓)	✓	✓	✓
Closing the interview & setting up next meeting		✓	✓	✓		
<b>Recommended skills</b>						
Active listening	✓	✓	✓	✓	✓	✓
Empathy	✓		✓	✓	✓	✓
Responding to verbal/non verbal cues		✓	✓	✓	✓	✓
Attention to questioning style (open/closed, etc.)	✓	✓	✓	✓	✓	✓
Summarizing		✓	✓	✓	✓	✓
Explanation and planning			✓	(✓)		
Structuring	(✓)	(✓)	✓	✓		✓
Reflection			✓	✓		✓
Clarification		✓	✓	✓		✓
Chunking information and checking understanding		✓	✓	(✓)	✓	✓
Adapting to language level				✓		
<b>Specific Tasks</b>						
Breaking bad news	✓		✓		✓	
Specific clinical contexts e.g. psychiatric disorders anxiety/depression/aggression				(✓)		
Cultural/social diversity		✓	✓	✓	✓	
Handling emotions/difficult questions		✓	✓	✓	✓	✓
Dealing with uncertainty			✓	✓		✓
Age specific i.e. children		✓	✓	(✓)		
Sensitive issues e.g. sex, death and dying	✓		✓	✓	✓	
Triadic consultations/emergency			✓	✓		
Dealing with errors/mistakes			✓	✓		
Team-/inter-professional communication, leadership			✓	✓		
Communication impairment			✓	✓		
Media			✓	✓		

(✓)= not explicitly mentioned or subsumed.

that made up a preliminary coding scheme. Coders then compared their coding to achieve consensus on the coding scheme and then codes were reviewed to ensure that all comments could be categorized by these main themes.

### 3. Results

#### 3.1. Participants of the consensus process

In total, 121 communication experts were included in the consensus process: 10 from the core curriculum group of tEACH, 27 members of tEACH not in the core curriculum subgroup (Delphi round 1 and 2), and 84 multi-professional communication experts outside of tEACH from 16 European countries representing Azerbaijan, Belgium, Denmark, Germany, Greece, Ireland, Israel, Italy, the Netherlands, Norway, Poland, Portugal, Romania, Spain, Switzerland and the United Kingdom (Delphi round 3). Participants in this final Delphi round (*n* = 84) came from 15 professional fields including medicine, psychology, dentistry, nursing, pharmacy, midwifery, speech- and language-therapy, osteopathy, physiotherapy, health communication, education, social work, sociology, specialists in cultural competence and Simulated Patient programs. 47 participants came from non-medical and 37 from medical professions (Fig. 2). 60.7% (*n* = 51) of the participants were female. The average amount of experience participants had in teaching and/or assessing communication skills was 12.38 years. While one third worked in either undergraduate or postgraduate education, two thirds worked with learners in both. About one fourth worked in more than one professional field (e.g. medicine and nursing). Presentation of results focuses on responses from 84 participants in Delphi round 3.

#### 3.2. Quantitative analysis

The acceptance of the 61 core communication curriculum objectives was very high (Table 2). Quantitative analysis revealed that on average all communication objectives had a high relevance for education in all health care professions with a range from 84 to 100%. 11 objectives had an acceptance of 100%, which means all experts had rated the objectives as most important, very important or important. 45 objectives had an acceptance of 90–99% and 5 objectives had an acceptance of 84–89% indicating that some participants rated these objectives as somewhat unimportant or unimportant. Means, standard

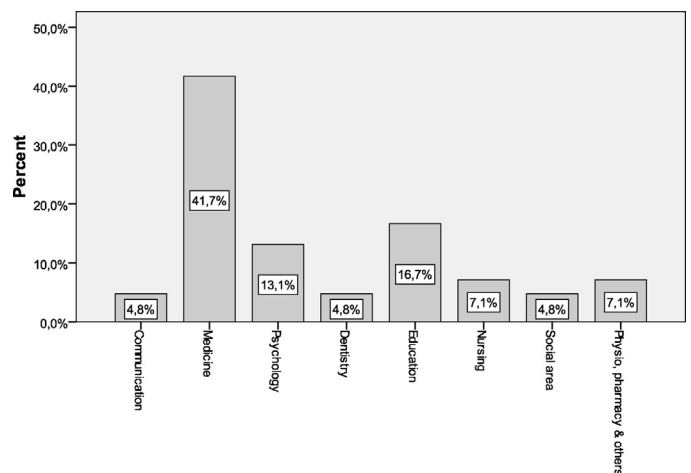


Fig. 2. Professions of participants.

**Table 2**

The Health Professions Core Communication Curriculum: objectives for undergraduate education in health care professions.

	Mean <sup>a</sup> (SD)	Acceptance <sup>b</sup> in %
<b>A. Communication with patients</b>		
<b>Core communication objectives:</b>		
<b>The student . . .</b>		
1 Adapts own communication to the level of understanding and language of the patient, avoiding jargon.	1.41 (0.59)	100.0
2 Uses techniques to build up and maintain rapport and an empathetic relationship and ensures that the patient feels attended and listened to.	1.45 (0.70)	100.0
3 Relates to the patient respectfully including ensuring confidentiality, privacy and autonomy and recognizes the patient as a partner in shaping a relationship.	1.47 (0.69)	98.8
4 Elicits and explores the content of the patient's bio-psycho-social history (e.g. gathers relevant information, ensures understanding, relays information understandably, verbalizes emotional content).	1.53 (0.67)	100.0
5 Encourages the patient to express own ideas, concerns, expectations and feelings and accepts legitimacy of patient's views and feelings.	1.54 (0.74)	98.8
6 Gives information to the patient (oral, written, electronic and over the phone) in a timely, comprehensive and meaningful manner.	1.54 (0.67)	100.0
7 Uses techniques of active listening (e.g. reflection, picking up patient's cues, paraphrasing, summarizing, verbal and non-verbal techniques).	1.57 (0.74)	98.8
8 Recognizes difficult situations and communication challenges (e.g. crying, strong emotional feelings, interruptions, aggression, anger, anxiety, embarrassing or sensitive issues, cognitive impairment, delivering bad news) and deals with them sensitively and constructively.	1.57 (0.70)	100.0
9 Shows awareness of the non-verbal communication of both the patient and the healthcare professional (e.g. eye contact, gestures, facial expressions, posture) and responds to them appropriately.	1.60 (0.68)	100.0
10 Shapes a conversation from beginning to end with regard to structure (e.g. introduction, initiating the conversation, gathering and giving information, planning, closing interview, setting up next meeting; time management).	1.72 (0.82)	97.6
11 Uses different types of questions (e.g. open, closed and focused) according to the situation.	1.78 (0.78)	98.8
<b>More detailed specific objectives, depending on context and situation:</b>		
<b>Shaping of relationship: The student involves the patient in the interaction to establish a therapeutic relationship using a patient-centered approach</b>		
12 Identifies patient expectations with respect to the role of health care professional.	1.81 (0.74)	100.0
13 Uses adequate strategies to solve conflicts (e.g. feedback on perception, impact, wishes).	2.12 (0.85)	95.2
<b>Patient's perspective and health beliefs: The student orients own communication in line with the actual needs and concerns of the patient</b>		
14 Elicits the needs and capabilities of the patient (e.g. information, autonomy, truth and responsibility) and adapts the plan/intervention to patient's resources and strengths.	1.71 (0.79)	100.0
15 Considers somatic, mental, social, gender, cultural, ethical and spiritual elements in the care and assessment of the patient and perceives divergences between own values and norms and the patient's.	1.92 (0.83)	98.8
16 Responds to the patient's health beliefs and theories of illness and contrasts and integrates these into own theories of illness as a health care professional.	2.02 (0.89)	96.3
<b>Information: The student effectively collects and communicates relevant information for reasoning and decision-making</b>		
17 Finds out how much information the patient requires and gives the appropriate amount of information.	1.71 (0.71)	100.0
18 Provides information in a patient-centered way and shares it with the patient's consent (e.g. colleagues, family and others.)	1.81 (0.82)	97.6
19 Elicits and synthesizes information for patient care.	1.83 (0.73)	100.0
20 Inquires about the patient's level of knowledge about the illness	1.87 (0.79)	98.8
21 Considers different elements of a patient history (history of the illness, history of the health care professional-patient relationship, history of the patient).	2.10 (0.86)	95.1
22 Knows about the importance of supplementing verbal information with diagrams, models, written information and instructions and applies the information appropriately.	2.18 (0.89)	94.0
23 Seeks out and synthesizes relevant information from other sources (e.g. patient's family, caregivers and other professionals), if necessary and available	2.19 (0.90)	94.0
<b>Reasoning and decision-making: The student considers the extent to which individuals are involved and responsible in the reasoning and decision-making process</b>		
24 Ascertains how much involvement and responsibility the patient is willing and able to take for decision-making.	1.77 (0.79)	97.6
25 Discusses with the patient the likely advantages, disadvantages and expected outcomes	1.80 (0.76)	100.0
26 Encourages active participation by the patient in decision-making and explains choices or rights to the patient in a patient-centered manner.	1.82 (0.86)	96.3
27 Clarifies own role in decision-making process.	1.96 (0.98)	95.2
28 Discusses with patient the spectrum of possible consequences of a decision and explains to the patient the likely consequences of not choosing diagnostic and therapeutic measures.	2.02 (1.01)	94.0
29 Inquires about the relevant psychological and social resources the patient has available for making a decision.	2.06 (1.03)	92.6
30 Offers the patient the option to include other people in the decision-making process and clarifies with the patient how and when a decision must be made.	2.22 (1.08)	90.4
31 Discusses decisions with colleagues, patients and their relatives as appropriate and regularly reassesses own decisions and revises them if necessary.	2.23 (0.98)	94.0
32 Identifies own opinion clearly to the patient if asked.	2.30 (1.10)	86.4
<b>Uncertainty: The student respects uncertainty as an integral part of reasoning and decision-making</b>		
33 Talks openly to the patient about uncertainty and formulates ways of dealing with it.	2.11 (0.92)	95.1
34 Explains to the patient which information is needed to minimize uncertainty in the decision-making process.	2.22 (1.00)	91.4
<b>B. Intra- and interpersonal communication (Professionalism and Reflection)</b>		
<b>Communication and reflection with self and others: The student consistently develops and improves self-awareness, self-reflection, self-care and reflects with others on own communication and behavior</b>		
1 Recognizes own emotions (e.g. insecurity, sympathy/antipathy, attraction) in relation to others (e.g. patients, colleagues) and is able to work efficiently despite own emotional reactions when the situation requires to do so (e.g. degree of suffering of the patient, demanding patient).	1.55 (0.82)	98.8

Table 2 (Continued)

		Mean <sup>a</sup> (SD)	Acceptance <sup>b</sup> in %
2	Recognizes that effective communication with patients can foster patients' satisfaction and improved clinical outcomes.	1.64 (0.81)	97.5
3	Describes and assesses own communication and behavior critically considering alternatives in both.	1.77 (0.82)	98.8
4	Identifies, reflects and communicates own strengths, weaknesses, limitations and assesses own wishes, fears, goals, norms and values.	1.83 (0.80)	98.8
5	Assesses own stereotypes and social prejudices and is aware that own actions are influenced by personal experience, the current situation, own knowledge and interests.	1.93 (0.91)	97.6
6	Reflects on own attitude towards work (e.g. cynicism, satisfaction).	2.05 (0.87)	95.1
7	Reflects and discusses ethical, inter-cultural and other challenges in own actions as a health care professional (e.g. patient unable to give consent, health/illness concepts in different cultures, translators) and discusses approaches for resolution.	2.12 (0.99)	91.5
8	Uses authority and influence responsibly.	2.15 (1.01)	88.9
9	Analyses and discusses conversational situations with others (metacommunication in e.g. peer reflection, team conferences, Balint groups).	2.30 (1.04)	85.4
10	Knows about models of the health care professional–patient relationship (e.g. transference/counter transference, reciprocity, inter-subjectivity, expectation/experience, potential imbalance of hierarchy).	2.48 (1.03)	84.1
<b>Dealing with errors and uncertainty: The student addresses errors and respects uncertainty as an integral part of reasoning and decision-making</b>			
11	Addresses own and others errors appropriately (e.g. refrains from personally allocating blame) in order to seek for solutions and assistance and knows about basic principles in the development of errors (e.g. neglecting information or patient's needs, inadequate communication).	1.80 (0.85)	96.4
12	Addresses and deals with own uncertainty appropriate to own level of education.	1.91 (0.84)	97.5
<b>C. Communication in health care teams (professional communication)</b>			
<b>Teamwork and professional communication: The student shows ability to communicate effectively in multi-professional teams</b>			
1	Perceives and respects individuality, subjective perception, different points of view of team members and the expertise of the different health care professionals.	1.83 (0.94)	95.1
2	Contributes to a positive working atmosphere (e.g. supports and integrates team members, mentions the positive side of unpleasant aspects, values team-success).	1.90 (0.90)	96.3
3	Uses feedback rules (e.g. first-person-statements) and gives feedback to team-members appropriately.	1.90 (0.91)	98.8
4	Is able to solve conflicts and enables a constructive negotiation in a healthcare team.	1.96 (0.92)	93.8
5	Takes on, clarifies and reflects on own role and responsibilities in the team (e.g. team vs. team-player, leader) and identifies the role of own profession in an inter-professional team.	2.04 (0.92)	95.1
6	Specifies and appreciates own potential with regard to the team and is willing and able to work with others.	2.01 (0.90)	93.9
7	Understands the principles of team dynamics and how factors both support and inhibit teamwork in practice.	2.29 (0.88)	95.1
8	Identifies own interests and distinguishes these from the team goals.	2.26 (1.02)	90.2
9	Reflects on the impact of own opinion on others and takes this into account.	2.32 (1.00)	88.9
<b>Leadership: The student shows basic competencies in leadership skills</b>			
10	Gives clear instructions.	1.87 (0.91)	94.0
11	Ensures that all relevant information is available.	2.04 (0.87)	93.9
12	Facilitates the formation of opinions in the group and encourages and rewards team members to voice differing opinions.	2.20 (0.91)	92.7
<b>Professional communication and management: The student uses effective and efficient communication and management strategies</b>			
13	Maintains clear, appropriate records (written or electronic) of clinical encounters and plans.	1.75 (0.84)	98.8
14	Presents expert knowledge effectively (e.g. presenting a patient and clinical details to others, speaking in front of a group, presenting scientific data).	1.82 (0.83)	98.8
15	Identifies and is knowledgeable of how to refer to people/institutions/agencies that can help to solve problems appropriate to the situation.	1.93 (0.87)	98.8

<sup>a</sup> **Ranking of objectives:** 1 = most important; 2 = very important; 3 = important; 4 = rather unimportant; 5 = unimportant.

<sup>b</sup> **Definition of acceptance:** % of participants who rated objectives as most important, very important or important (e.g. 100% acceptance means that all participants rated the objective in one of the three categories).

deviations and acceptance are listed in Table 2. Highest relevance was found among objectives for core communication skills with patients, followed by intra- and inter-professional communication and communication in health care teams. 11 objectives reached a median of 1 (most important), 49 had a median of 2 (very important) and one had a median of 3 (important). Some participants ranked single objectives as unimportant but none of the learning objectives had a median of 4 (rather unimportant) or 5 (unimportant).

For 'communication with patients' those perceived as most important objectives included: adaptation to patient's understanding and language, empathic relationship building and maintenance, respect and partnership, exploration of the content of the patient's history, patients' expectations, needs and feelings, giving information, active listening and awareness to non-verbal communication, sensitivity towards difficult situations and communication challenges. Also self-reflective learning objectives were scored as most important, such as recognition of own emotions and effectiveness of communication and improved clinical outcomes.

Non-parametric tests (Mann–Whitney *U*) were conducted to ascertain statistical associations between main professional areas. No statistical significance was found between the different professions in how they rated the objectives.

### 3.3. Qualitative analysis

72 of the 84 participants responded to the question asking them to comment on the HPCCC as a whole and these comments helped to explain participants' ratings. Overall, the comments were very positive, describing the curriculum objectives as well designed and comprehensive and the curriculum as a highly relevant tool. Thematic analysis enabled the identification of three broad categories: 1) importance of the document; 2) shortcomings and demands; and 3) process of implementation, training and assessment measures additional to the core curriculum.

Typical comments in regard to the importance of the objectives stated that the core curriculum is "very important for the education process of all health care providers" or "very applicable" or "includes all relevant issues". The comments included phrases like:

“Wonderful, it is exactly what we would like to teach our students”, “excellent and comprehensive”, “a rich and systematic tool” and “it is a good balance of the different functions of communication acts”. Most experts appreciated the detailed description of learning objectives, the innovative approach, the importance of defining communication goals for all health care professions and the benefit of having a structured and comprehensive tool that covers all important aspects of communication.

Some individual participants made suggestions for additions to the HPCCC such as motivational interviewing or working with language minorities or a more detailed specification of target groups like communication with children, elderly, psychiatric patients, and speech disabilities.

Some respondents ( $n = 9$ ) were concerned about implementation issues related to the curriculum, specifically the length of the curriculum or ambitious objectives and suggested a need to prioritize the list, which is now available. Most important learning objectives can be extracted from the HPCCC by using the ranking scores of means or “acceptance of objectives” (Table 2), but the great majority felt that e.g. “it is hard to see how any of it is unimportant”. Some participants ( $n = 8$ ) noted that having additional information about implementation of the curriculum including such aspects as amount and intensity of training, time constraints, and assessment would be helpful.

Participants were also asked to indicate, if they could use the core curriculum for undergraduate education in their own professional field. 97.2% of the participants who answered the question ( $n = 71$ ), responded positively stating they could either use it as a whole ( $n = 60$ ) or with modification in parts ( $n = 9$ ). Some participants ( $n = 8$ ) expressed that the curriculum was very similar to their own existing program. Of those who did not answer the question about applicability in the own profession ( $n = 13$ ), no one gave a negative statement on the curriculum as a whole and no statistically relevant difference was found between the two groups – those who answered the applicability question and those who did not – with regard to acceptance of learning objectives.

## 4. Discussion and conclusion

### 4.1. Discussion

Effective communication should be a major goal for all health care education. Our approach to developing objectives for a comprehensive inter- and multi-professional communication curriculum was based on the assumption that in communication with patients, their relatives and in health care teams, core skills are common to all health professionals. Effective communication should be the same whether done by a nurse, pharmacist, dentist, doctor or other specialist. Therefore, common communication skills applicable in all health care professions should be taught in undergraduate or pre-registration education. Consensus statements, frameworks, model curricula and relevant seminal papers from different countries and professions exist, but the current work is the first inter- and multi-professional, European consensus approach to be carried out.

The inter-professional information exchange between European communication experts from 16 different countries within tEACH, along with the analysis of the literature, revealed deficiencies in the curricular development of communication skills training for the different health care professions across Europe. Some health care professions lack communication curricula completely with only a few non-medical professions having systematically implemented any communication curricula into their undergraduate education. Whilst medical schools have led the way in several European countries, some countries and many health care professions have just or not yet started to

implement communication into their undergraduate education. The state of development and implementation within the different European countries and health care professions is heterogeneous indicating a need for the development of an inter- and multi-professional European solution. This would also contribute to addressing demands of the Bologna Initiative for comparable curricula in European higher education.

### 4.1.1. Main results

An international and multi-professional expert group developed a core communication curriculum to be applicable in undergraduate education in all health care professions. The Health Professionals Core Communication Curriculum aims to serve as a guideline for objectives to be taught in undergraduate/pre-registration education. The learning objectives focus not only on ‘communication with patients’ but also on ‘communication in inter- and multi-professional teams’ as well as ‘professionalism and reflection’.

The HPCCC provides 61 learning objectives for undergraduate education to be accomplished by the end of the various health care degree programs. The overall acceptance by communication experts on these objectives was very high. Comments by participants in the consensus process indicated the need for and importance of a tool like the HPCCC and appreciation for its comprehensiveness. The ranking of importance of each subject as measured by means and “acceptance of objective” gives an insight into the relevance of the different skills and most important objectives can now be deduced from the HPCCC. The request from some consensus participants to highlight most important skills is therefore given. As the taxonomy of the objectives was adapted to the Basel Consensus Statement [16] with a detailed, skills-based description of objectives, the HPCCC aims to use the objectives for teaching and it could also be used for assessment.

### 4.1.2. Findings in relation to relevant literature

The HPCCC builds on and extends existing consensus statements available in the literature and offers a new inter- and multi-professional approach to teaching communication in health care. While several consensus statements on communication skills teaching for medical education exist [13–18], the majority of these were based on consensus of a comparatively smaller number with 21–33 expert participants in the consensus process. The Basel Consensus Statement [16] is based on the broad acceptance of more than 100 communication experts and due to the skills-based taxonomy it was a comprehensive tool for the development of the HPCCC. Unfortunately, we were unable to find any communication consensus statements for non-medical professions in our literature search in various languages and countries, which was congruent with our inter-professional expert information exchange indicating that comprehensive communication skills models and training has not been well developed outside of medicine. In addition to these findings, the literature does not contain any blueprint for an inter- or multi-professional approach to delineating communication skills. Therefore, the HPCCC adds to this body of literature through its emphasis on inter- and multi-professional objectives and can be a beneficial tool for many health care professions.

### 4.1.3. Limitations and implications for future directions

The HPCCC has been evaluated focusing on inter- and multi-professional application of the learning objectives in multiple Delphi process steps by 121 multi-professional and international communication experts. The participants of the final Delphi process were personally recruited by tEACH members, who knew that these experts had experience in teaching communication in their own professional field and expertise to evaluate the relevance of the different learning objectives. Many experts in the final

Delphi round came from medical education, revealing the high expertise in this professional field and relating to the current state of curriculum development in many European countries, whilst it was challenging to find communication experts in other professions. More expertise from non-medical professions might have enhanced the process. Still, nearly 60% of our experts came from non-medical education and our results showed no difference related to professional area in regard to acceptance of the objectives. We therefore presume that the HPCCC can serve as a guideline for curricular development in different health care professions and between them. Thus, the curriculum can also lead the way to enforce the goals of the Bologna process.

The HPCCC does not yet provide a direction for when and how to teach or assess the different objectives as some communication experts asked for in their comments, and discussion of these issues is beyond the scope of the current paper. Following the Kern model of curriculum development [58], the next step for the tEACH group will be to complement the objectives with appropriate teaching and assessment tools as well as suggestions for qualified train-the-trainer programs and evaluation systems.

The communication experts came from various professional fields, countries and cultural backgrounds. We were unable to undertake elaborated subgroup analyses with regard to countries or cultures as some of the subgroups were too small. While we found some higher standard deviations on some objectives, we could not find clear patterns based on professional field or rater country of origin to explain these differences. Future research on the HPCCC, using larger and more representative samples, could examine how professional background and/or country of origin and cultural differences influence levels of acceptance of specific objectives. In addition, perspectives of patients and students on the relative importance of HPCCC objectives could be explored.

The HPCCC, based on a broad multi-professional consensus process, provides common core communication learning objectives for undergraduate education in health care professions. Due to the high acceptance among European communication experts from various health care disciplines the HPCCC can be used inter- and multi-professionally by applying objectives within but also amongst the various health care professions. Still, the HPCCC cannot be static but must reflect changes within the health care culture and the broader society as a whole. Therefore, what we have proposed is a dynamic, flexible framework, which can be expanded or reduced. Means and “acceptance” point to those objectives which were considered most important to include in communication skills curriculum and also identify potentially new objectives that could be added to already existing curricula. We decided to focus the HPCCC on undergraduate education applicable in all health care professions and European countries but we presume that the HPCCC can and will be adapted to the specific needs of individual professions and reflect the diverse and changing communication challenges of health professionals. Areas for consideration in the future could include dealing with electronic media information, goal setting and monitoring, motivational interviewing, and communicating with specific target groups or translators. Further refinement of the objectives might focus on the salience and importance of the expert consensus as seen from the patient’s perspective. Future investigation will be needed to give insight into implementation and adoption processes.

#### 4.2. Conclusion

A core communication curriculum for undergraduate or pre-registration education in health care professions was developed by an expert group and consented in a European Delphi process with

121 multi-professional communication experts. 61 learning objectives were defined in a detailed, skills-based taxonomy and a ranking score reveals the relevance of each objective. The communication curriculum achieved high acceptance among European communication experts and can now be used as an inter- and multi-professional guideline for curriculum development within and among the different European countries and health care professions and it can give support to enhance the Bologna process.

#### 4.3. Practice implications

The European consensus on objectives for a Health Professions Core Communication Curriculum delivers a framework for health care professions and institutions that plan to implement communication into their curricula or that want to restructure their teaching or assessment in communication. The HPCCC can be used inter- and multi-professionally. As non-medical consensus statements do not exist and many professions and countries have not or just started to integrate communication into health care education, the HPCCC can also give legitimacy and support for curriculum development processes in the various health care disciplines. The core curriculum covers elements that should be part of undergraduate communication curricula in health care but the HPCCC is meant as a flexible framework and can be implemented into curricula as a whole or in parts. It can be used as a guide for teaching communication skills and for developing assessments. The decision regarding the extent to which the different objectives are implemented, taught and assessed should be left to the discretion of the different institutions as teaching loads, staff capacities and logistics as well as assessment facilities have to be adapted individually at each institution. With growing experience on implementation processes of the HPCCC, research and re-evaluation of the core communication curriculum will need to follow in future.

#### Conflict of interests

The authors have no conflicts of interest.

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