

Teaching communication as a core competency in health professions education: An exploratory case study in a college of health sciences, South Africa

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Background. Competency-based and interprofessional education are increasingly favoured approaches for training health professionals (HPs) to meet patient and population needs. The Health Professions Council of South Africa (HPCSA) and College of Health Sciences (CHS) at the University of KwaZulu-Natal, Durban, SA, specified a requirement for a core competencies framework to be incorporated into all HP programmes in 2014.

Objectives. To explore teaching, learning and assessment of communication as a core competency in eight HP programmes in the CHS to determine how communication was taught and whether the competencies framework had been adopted successfully. The study is important, as there has been limited research on the teaching of communication as a competency in HP education in SA.

Methods. The case study comprised educational qualitative research. The CHS document was reviewed and purposive sampling was used to select educators from the programmes. Focus group discussions were conducted in July and August 2015 with 5 - 9 participants per group. Data were analysed thematically and themes and subthemes described. Gatekeeper and ethical permissions were obtained.

Results. Aspects of communication were taught in all programmes. None of the programmes had fully incorporated the CHS framework. The medicine programme had incorporated aspects of the framework in teaching, although it did not reflect consistently in all disciplines. Teaching was largely profession or discipline specific. Important challenges were language barriers and interprofessional communication.

Conclusions. While the consistent use of the CHS core competencies framework may contribute to improving the teaching of communication in the HP programmes, the success of a competency-based approach depends on responsiveness to context. Research in local settings is recommended to identify and align competencies and content with patient and community needs.

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The World Health Organization emphasises that curriculum reform should be geared to population needs and inequalities in health.^[1] A seminal report in the *Lancet*^[2] called for major reforms in health professional (HP) education, recommending a competency-based approach and the reorientation of health services to meet patient and population needs in the 21st century. Contrary to traditional educational practices, which concentrate on what and how learners are taught, competency-based education (CBE) attends to the performance or goal state of instruction^[3-5] to ensure that learners can use their learning to communicate well, assess and manage patients effectively, solve problems and make good clinical decisions in practice. As competencies are context dependent, it is important that context-specific health issues are used to ensure that the desired competencies are aligned with population needs. Assessment and evaluation of competencies should be conducted in context.^[2,3,6,7]

Of concern is that efforts to counter existing deficiencies in HP education faltered, in part due to the tendency of various professions to act in isolation from, or even in competition with, each other.^[2] An interprofessional (IP) approach has been recommended to support student learning and collaboration in future practice.^[8,9] The outcomes for a shared patient are improved by reconfiguring activities to be interteam and IP based.^[10] Teamwork is also important for information sharing and developing new

work practices to reduce error in changing contexts.^[9] In South Africa (SA), communication between HPs, and particularly communication with patients, in both the public and private sectors, is affected by population complexity and diversity, and varying backgrounds, languages and literacy levels.^[11] IP communication is also influenced by the hierarchical nature of role players in the healthcare system.^[11]

Against this background the Health Professions Council of SA (HPCSA) specified the inclusion of a set of seven core competencies, including communication, in the medical, dental and medical associate undergraduate programmes.^[12] This HPCSA framework was based on the Royal College of Physicians and Surgeons of Canada Core Competencies Document for Postgraduate Education (CanMEDS),^[13] ensuring coherence between under- and postgraduate education. The College of Health Sciences (CHS) at the University of KwaZulu-Natal (UKZN), Durban, SA, subsequently expanded its application to include all HP programmes in the college^[14] (Fig. 1) in 2014 to emphasise the importance of these competencies for all HPs involved in healthcare.

Of interest in this study is the role of communicator. With the incontrovertible evidence for the benefits of good communication in healthcare,^[15] communication teaching is now an integral part of HP curricula worldwide.^[16-18] Good communication is important, not only

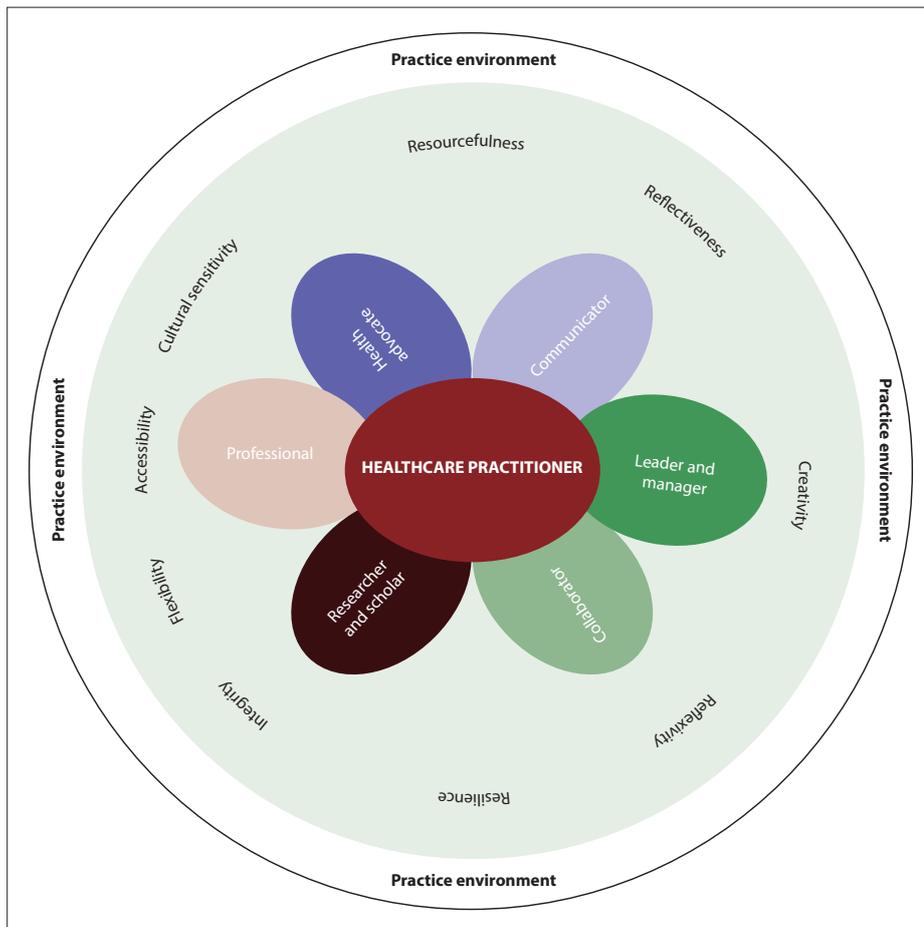


Fig. 1. The core competencies framework for undergraduate students in the College of Health Sciences (CHS) at the University of KwaZulu-Natal (developed by the CHS teaching and learning task team in collaboration with KwaZulu-Natal Provincial Department of Health representatives, stakeholders and interested parties (2014)^[14]).

in the practitioner-patient context, but also in relating with communities served by the HP team, and in IP communication in the healthcare context.^[18]

The key and enabling competencies for communication described in the CHS framework^[14] therefore promote communication and the development of ethical relationships with patients (or clients) and their families and communities, as well as with colleagues and other professionals. Further key competencies include the ability to accurately synthesise relevant information, convey explanations and develop a shared plan of care with patients. Conveying oral and written information accurately to colleagues and other professionals is also deemed essential.^[14] Key competencies are listed in Appendix 1.

Professional training in the CHS, where the medium of instruction is English, aims to produce primary healthcare providers^[19] in a region where patients are predominantly

isiZulu mother-tongue speakers.^[20] In the process of integrating the CHS core competencies into professional programmes, there is concern about whether there is appropriate focus on the development of communication skills, and whether clinical educators feel competent to demonstrate these skills and develop them in their students, particularly if the educators have not received formal training in communication.

This study explored the teaching, learning and assessment (TLA) of communication as a core competency with academic staff in eight HP programmes in the CHS (optometry (Opt), physiotherapy (Physio), pharmacy (Pharm), medicine (Med), speech-language pathology (SLP), dental therapy (DT), audiology (Audio), and occupational therapy (OT)). The overall objective was to determine if the CHS framework had been adopted and how communication was included in the HP curricula.

The specific research objectives were to determine:

- whether communication was being taught and assessed as a core competency in the HP programmes
- whether the CHS core competencies framework had been successfully adopted in teaching communication
- the approach to the TLA of communication
- HP educators' ideas and concerns about TLA of communication
- educators' opinions regarding communication teaching that reflects contextual needs in practice.

As there has been limited research on the use of CBE in the communicator role in local HP education, the study was considered important to guide curriculum reform to respond to local health needs.

Methods

Study design

A qualitative case study design was used.^[21] It was an educational study in the interpretivist paradigm to allow for exploration of participants' views.

Positionality of the researcher

Both researchers have been involved in the development and teaching of communication in the medical programme and in qualitative educational research. MM is an experienced medical practitioner working in education, and TN is a clinical psychologist. The study improved our understanding of the topic by including other HP educators, as well as medical educators.

Setting

The study was conducted in the CHS of an SA university.

Study population and sample

The study population comprised academic staff who teach undergraduates in eight HP programmes. Participants were purposively sampled for their in-depth knowledge of content and approach to the TLA of communication in the modules, and invited by the office of the dean of teaching and learning to participate. The final samples included academic leaders (academic heads for the programme or discipline) and year or module co-ordinators, described in more detail in Table 1.

Data collection

A series of academic meetings was held by the dean of teaching and learning and senior academics in the schools that would be involved in research to plan the study and review the CHS framework. Data were collected during focus group discussions (FGDs) in July and August 2015. Educators were interviewed in professional groups of 5 - 9 participants. For logistical reasons, educators in the medical programme were interviewed in two groups.

Both researchers were present for the FGDs – one facilitating the discussion, and the co-facilitator observing and keeping notes. A semi-structured set of prompt questions initiated the discussions. Reflective questioning related to the topic offered opportunities to explore the knowledge, skills and attitudes of participants.^[22] This method allowed the facilitator to maintain a sense of the progress of the dialogue, while taking cues for follow-up questions to explore the responses of participants in greater depth. Audio recordings were professionally transcribed, and the researchers checked the transcripts for accuracy against the audio recordings.

Data analysis

Data analysis was conducted in five phases (Table 2).

Trustworthiness

The study method is described against the consolidated criteria for reporting qualitative research. Rigour and robustness of data were ensured in the manner described. Firstly, good representation of HP educators by profession was ensured in the samples. Duration of the FGDs was 45 - 75 minutes to ensure data saturation in the larger groups. Member checking was done during the FGDs for participant validation of the content. Dependability of the data was achieved through the use of an audit trail during the data collection and analysis process.^[23]

Ethical approval

Gatekeeper and ethical permission was obtained from the UKZN Humanities and Social Sciences Research Ethics Committee (ref. no. HSS/0415/015; 1633/014D).

Normal ethical guidelines were followed. In terms of basic ethical principles, individual informed written consent was obtained from each study participant after a verbal briefing and sharing an information sheet describing the nature of the study. Participation was voluntary and participants were assured of anonymity of their responses. No identifying information was included with the data. As it was an educational study, there was no risk to participants, who were informed that the general benefit of the study would be to improve the teaching and learning of communication in HP education.

Results

With regard to the first objective, educators in all HP programmes indicated that aspects of communication were included in teaching. In response to the second objective, it was found that no HP programme had developed an overarching pedagogical approach to the teaching of communication. Only the medicine programme had adopted the CHS framework, albeit partially; it did not reflect consistently across all disciplines. Educators in all programmes except medicine acknowledged that students would not be able to identify aspects of teaching that pertained to communication as a core competency, as this was not defined in formal learning objectives.

The data were explored further to respond to research questions 3 - 5. The main and subthemes identified are summarised in Table 3.

General approach to teaching, learning and assessment of communication

Teaching, learning and assessment approaches and methods

In medicine, skills related to communication process and content were taught explicitly in the first 3 (preclinical) years, and during the family

Table 1. Focus group discussions and description of participants

Health professional programme	Focus group number	Participants, <i>n</i>	Description of participants
Optometry	1	9	1 AL/L, 2 SL, 6 L, 7 F, 2 M
Physiotherapy	2	9	1 AL/L, 1 SL, 1 L, 3 L (part-time), 3 ST, 5 F, 4 M
Pharmacy	3	6	1 Prof, 1 AL/SL, 2 SL, 2 L, 3 F, 3 M
Medicine (2 × 8 participants)	4	16	1 AL/Assoc Prof, 1 AL/SL, 7 SL, 6 L, 1 PPO, 10 F, 6 M
Speech-language pathology	5	7	1 AL/L, 1 SL, 4 L, 1 ST, 7 F
Dental therapy	6	5	1 SL, 3 L, 1 ST, 4 F, 1 M
Audiology	7	5	1 AL/SL, 4 L, 5 F
Occupational therapy	8	7	1 Assoc Prof, 4 L, 1 DL, 1 tutor, 5 F, 2 M

AL = academic leader; L = lecturer; SL = senior lecturer; F = female; M = male; ST = senior tutor; Prof = professor; Assoc Prof = associate professor; PPO = principal programme officer; DL = developmental lecturer.

Table 2. Phases in data analysis

Phase	Process
1	Two researchers independently familiarised themselves with the data
2	Each researcher independently coded the data for themes against the College of Health Sciences core competencies framework
3	One researcher then coded the data on NVivo 10 (QSR International) qualitative data analysis software for these themes
4	Themes were refined and subcategorised into meaningful elements related to the purpose of the study, relevant literature and subthemes Memos and notes were used to describe patterns in the data
5	Themes were reviewed and discussed in an iterative process, then further condensed, combined or excluded, based on consensus between the researchers

Table 3. Main themes and subthemes

Main themes	Subthemes
General approach to TLA	TLA approaches and methods Profession-specific communication teaching
Contextual lessons on broadening the scope of communication in HP education	Language in communication Communication beyond the patient with families and communities IP communication and teamwork
Group reflections on including the CHS framework in the curriculum and improving communication teaching	Use of a consistent framework; increased focus on communication teaching with specific learning objectives; teaching integrated with professional content; staff development; improving IP communication and responding to the language requirement

TLA = teaching, learning and assessment; HP = health professional; IP = interprofessional; CHS = College of Health Sciences.

medicine modules. The CHS framework had been introduced explicitly into teaching from the first year, linked to communication skills training. The other HP programmes included aspects of communication teaching and learning mainly implicitly, but explicitly in some modules. In general, the approach to teaching was module dependent and suited to the profession-specific need and scope of practice.

Most of the emphasis was on history taking from individual patients. In some programmes, counselling, a shared plan of care and aspects of oral and written communication were taught. There was less emphasis on teaching communication beyond the patient, to involve families, communities and other professionals. Teaching methods included didactic teaching, simulation and experiential learning in the clinical setting.

Assessment in some programmes included qualitative methods such as portfolios or case studies. Certain programmes included quantitative assessments in the form of objective structured clinical examinations (OSCEs), or a relatively small mark allocation for communication competence in clinical assessments. Importantly, workplace-based assessment⁽⁶⁾ of communication as a critical competency for graduating was not identified in any programme.

Communication skills were mentioned as being important in holistic patient care:

‘Initially we were very medical model focused, which meant that we were mostly interested in diagnosis and management, and now we are shifting into a more patient-holistic approach, wherein lies the need for communication skills.’ (FGD4 Med)

In some cases, communication was seen as a natural ability that did not need to be taught explicitly:

‘It is so much a part of us that we don’t see it, and we assume that students will have it because we have it.’ (FGD8 OT)

‘The assumption is, very often, when they go to the clinic, [the students] will just know how to talk to the child.’ (FGD5 SLP)

Some educators expected students to learn communication experientially by observation as they progressed through the programme:

‘It is like osmosis.’ (FGD1 Opt)

‘Communication happens along the way, whether right or wrong.’ (FGD1 Opt)

Educators appeared to value profession-specific knowledge over competency in communication, and in two programmes indicated that it was possible to graduate ‘good’ or ‘excellent’ clinicians who were poor communicators:

‘I feel you can be a good [professional] and still lack communication.’ (FGD2 Physio)

‘I think we can all attest to the fact that we have produced some excellent clinicians who are bad communicators, you know!’ (FGD1 Opt)

Profession-specific communication teaching

Professions in which communication was fundamental (e.g. Audio and SLP) focused on relevant aspects of communication teaching. SLP had experience with patients with specific communication challenges, and in IP collaborative practice with Audio. In DT, where the nature of interventions might inhibit communication, educators made specific efforts to address communication in teaching. OT included communication teaching in various modules and, with Audio, demonstrated strength in their strong relationships with the communities they served. Physio described the importance of a collaborative management plan formulated with patients, as adherence to home-exercise prescriptions was crucial to outcomes. Nonetheless, most of this teaching was implicit and subsumed within clinical training.

Contextual lessons on broadening the scope of communication in health professionals’ practice

Language in communication

Inability to speak isiZulu was a frequent challenge, experienced first-hand by educators and students in clinical and community settings. Educators described isiZulu taught in the first year as generic content not tailored to a professional clinical context (the exception to this being the isiZulu module in the medicine programme). Educators commented on the lack of trained interpreters in clinics, and several educators alluded to staff and students relying on other HPs or students to assist as interpreters when language or cultural challenges were experienced. All of these factors contributed to poor communication between HPs and patients:

‘You can learn Zulu but still not be able to communicate with a patient.’ (FGD2 Physio)

‘In the public sector [pharmacists] use assistants to do the counselling at the pharmacy and very little communication exists between the pharmacist and the patient. In the wards [pharmacists] use nurses or they simply focus on what is written down and speak to the doctors only and to the nurses, but never to the patient.’ (FGD3 Pharm)

‘For [students] it is easier to go to their colleagues in the class and say, “how do I say this, how do I ask that?”’ (FGD4 Med)

Some educators voiced concerns about learning a specific indigenous language in a country with 11 official languages, of which 9 were indigenous African languages. Educators referred to global migration and professional mobility of professionals around SA:

‘It is going to be a challenge. When you go to Pretoria they emphasise Tswana and in Venda they emphasise Venda. There is no way you can teach all the languages. Maybe you can create that appetite in students to [learn multiple languages], I don’t know how we can do it ...’ (FGD2 Physio)

Communication beyond the patient with families and communities

The importance of the ability to extend communication beyond practitioner-patient communication was acknowledged, but not specifically addressed as a key competency:

‘... there is another communication ... and it is the [HP] and the caregivers and parents. You get to a point where the whole family is there while you are treating a patient, so to have a skill to communicate with everyone, including the patient, including the kids ... How do you tell them about the patient’s condition?’ (FGD2 Physio)

Interprofessional communication and teamwork

IP communication formed an important subtheme:

‘We have shifted from just the doctor-patient relationship ... we now have a wider community that students have to be able to communicate with. It is about interprofessional communication.’ (FGD4 Med)

Of concern was that, generally, IP communication was perceived to be inadequate, both in the educational environment and in practice. Comments reflected poor oral and written communication, as well as a lack of respect between professionals:

‘... the way we talk to each other ... we don’t communicate well.’ (FGD4 Med)

‘Pharmacists very rarely engage with medical practitioners in writing, except in hospitals, and it is poorly done.’ (FGD3 Pharm)

‘... among our colleagues, [other HP] colleagues don’t respect you.’ (FGD4 Med)

Notwithstanding these concerns, only the OT and Audio programmes stressed the importance of teaching team dynamics and theory for effective community interventions:

‘... to actually know how to work in teams, team dynamics, and one of the key things is communication.’ (FGD7 Audio)

Group reflections on improving communication teaching

The collaborative process in the FGDs allowed reflection on the benefits of the use of a common framework in the CHS. HPs indicated that they would be best qualified to teach communication within their own programmes, integrated with content teaching, which is consistent with international trends.^[24] Staff development and collaboration with communication experts were suggested. Educators agreed that greater focus on communication teaching would emphasise its role in clinical competence, and suggested foregrounding communication early in training, coupled with an explanation of expected exit-level learning outcomes:

‘I think the student will look at communication a little bit differently if we have it upfront. Communication as a competency, this is how we are

going to teach it ... and at the end ... you can evaluate it yourself, do you have xyz in your communication competence? ... Students will look at it differently if we have it explicitly, not interwoven ... if we have a document that says, this is how we are going to address it.’ (FGD8 OT)

While educators were aware that language concordance and an IP and interdisciplinary approach in the clinical setting^[25] had been shown to improve patient outcomes, they nonetheless expressed concern about how the already limited time for teaching would be impacted by the inclusion of language teaching and addressing IP communication in programmes.

Discussion

Even though communication was included in HP teaching, the programmes had not successfully adopted the CHS framework. The approach to TLA was directed mainly at profession-specific needs and not at developing key and enabling competencies, which have been shown to promote effective communication in healthcare contexts.^[18]

Findings showed an overall bias towards a biomedical approach, profession-specific communication strategies and providing individual services for patients, with less emphasis on community-centred care. While the challenges of language barriers and benefits of language-concordant healthcare have been well documented,^[26] this study showed that language challenges had not been resolved. In spite of being specifically articulated in the CHS framework,^[14] broadening the conceptualisation of communication to include community in the context of HP education lacked emphasis. There was, however, acknowledgement of the need for communication beyond the patient, and for strategies that went beyond curative interventions into the preventive and primary realms of community care. The profession-specific strengths demonstrated in some HP programmes suggested opportunities for collaborative learning in IP practice contexts. IP communication, shown previously to be a challenge in the SA healthcare context,^[11] was acknowledged as a stumbling block in practice, but nonetheless had not been explicitly incorporated as a key competency for undergraduate students.

Communication in the workplace between SA healthcare providers and teams is affected by multiple and complex factors,^[11] and the rationale for CBE is to train students to be able to meet such workplace challenges.^[3,6] A theoretical perspective affords that educators, in spite of their concerns, had not successfully applied CBE to align their teaching methods with contextual needs. The issues of patient- and community-centred communication, language and IP communication in healthcare were closely related in the findings of this SA case study. Of concern was that some HPs still questioned the feasibility of learning indigenous languages to communicate with patients, stating that such communication was often effected by other HPs, called upon to act as language, cultural and health education brokers. This stance, contrary to a competency-based approach, may relegate competency in communication, particularly in indigenous languages, as an unnecessary luxury relative to a biomedical approach.

Critical questions were asked relating to how communication was taught in the CHS, and whether educators felt equipped to train students in communication for their context. The results of this study suggest that current communication training initiatives do not adequately prepare HP students for contextual needs in SA healthcare.

Study limitations

Participants were HP educators only. The data collected were based on the participants' experiences of communication teaching and clinical practice. Findings, while not generalisable, are intended to generate discussion on the teaching of communication using CBE in similar healthcare contexts.

Conclusions

Deficiencies in demonstrating and teaching good communication to undergraduates were evident. The main problems were a narrow biomedical emphasis in education and practice; language barriers; and insufficient emphasis on broadening communication teaching to include aspects such as IP communication in the healthcare team.

The CHS adoption of a CBE approach is intended to respond to local needs, and should be strongly supported in teaching and learning. Recommendations include raising awareness, staff development and use of champions in the HP programmes to improve teaching and encourage research in communication in local healthcare contexts. Improving communication in education and practice may be addressed partly by educators adopting the CHS framework, combined with IP learning, to unify the teaching approach across HP programmes. However, CBE theory suggests that responsiveness to context in curriculum development necessitates the identification of specific competencies by expert consensus in authentic SA healthcare settings to ensure fit-for-purpose graduates. Finally, deliverable outcomes in communication in HP programmes should be ensured through evaluation of key and enabling competencies in context, together with workplace-based assessment of HP students.

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1. World Health Organization. Transforming and Scaling Up Health Professions Education and Training: WHO Guidelines. Geneva: WHO, 2013.
2. Frenk J, Chen L, Bhutta C, et al. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *Lancet* 2010;376(9756):1923-1958. [https://doi.org/10.1016/s0140-6736\(10\)61854-5](https://doi.org/10.1016/s0140-6736(10)61854-5)
3. Gruppen LD, Burkhardt JC, Fitzgerald JT, et al. Competency-based education: Programme design and challenges to implementation. *Med Educ* 2012;50(5):532-539. <https://doi.org/10.1111/medu.12977>
4. Frank JR, Snell LS, ten Cate O, et al. Competency-based medical education: Theory to practice. *Med Teach* 2010;32(8):638-645. <https://doi.org/10.3109/0142159x.2010.501190>
5. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002;287(2):226-235. <https://doi.org/10.1001/jama.287.2.226>
6. Modi JN, Gupta P, Singh T. Competency-based medical education, entrustment and assessment. *Ind Pediatr* 2015;52(5):413-420. <https://doi.org/10.1007/s13312-015-0647-5>
7. Singh T, Modi J. Workplace based assessment: A step to promote competency based training. *Ind Pediatr* 2013;50(6):553-559. <https://doi.org/10.1007/s13312-013-0164-3>
8. World Health Organization. WHO framework for action on interprofessional education and collaborative practice. 2010. <http://www.who.int/iris/handle/10665/70185> (accessed 19 August 2019).
9. Roberts C, Kumar K. Student learning in interprofessional practice-based environments: What does theory say? *BMC Med Educ* 2015;26(15). <https://doi.org/10.1186/s12909-015-0492-1>
10. Bleakley A. Advances in Medical Education 3. Patient-Centred Medicine in Transition: The Heart of the Matter. Switzerland: Springer International Publishing, 2014.
11. Etheredge HR, Penn C, Watermeyer J. Interprofessional communication in organ transplantation in Gauteng Province, South Africa. *S Afr Med J* 2017;107(7):615-620. <https://doi.org/10.7196/samj.2017.v107i7.12355>
12. Health Professions Council of South Africa. Core Competencies for Undergraduate Students in the Clinical Associate, Dentistry and Medical Teaching and Learning Programmes in South Africa. Pretoria: HPCSA, 2012.
13. Royal College of Physicians and Surgeons of Canada. CanMEDS Physician Competencies for Postgraduate Education. Ottawa: Royal College of Physicians and Surgeons of Canada, 2005.
14. College of Health Sciences. Core Competencies for Undergraduate Students in the College of Health Sciences Teaching and Learning Programmes at the University of KwaZulu-Natal. Durban: UKZN, 2014.
15. Institute for Healthcare Communication. Impact of communication in healthcare. 2011. <http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/> (accessed 4 April 2018).
16. Makoul G. Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Acad Med* 2001;76(4):390-393. <https://doi.org/10.1097/00001888-200104000-00021>
17. Von Fragstein M, Silverman J, Cushing A, Quilligan S, Salisbury H, Wiskin C. UK consensus statement on the content of communication curricula in undergraduate medical education. *Med Educ* 2008;42(11):1100-1107. <https://doi.org/10.1111/j.1365-2923.2008.03137.x>
18. Health Professionals Core Communication Curriculum (HPCCC). Objectives for undergraduate education in health care professions. 2014. http://www.each.eu/wp-content/uploads/2014/07/HPCCC_website-tEACH.pdf (accessed 17 July 2017).
19. Botha F, Snyman E, Mchunu G, et al. University of KwaZulu-Natal College of Health Sciences and KwaZulu-Natal Department of Health Business Plan for Community Based Training in a Primary Health Care Model. Durban: UKZN, 2014.
20. Statistics South Africa. South African census. 2011. http://www.statssa.gov.za/census/census_2011/census_products/Census_2011_Census_in_brief.pdf (accessed 28 November 2017).
21. Yin RK. Case Study Research: Design and Methods. 3rd ed. Thousand Oaks, CA: Sage, 2003.
22. Lee G, Barnett B. Using reflective questioning to promote collaborative dialogue. *J Staff Develop* 1994;15(1).
23. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19(6):349-357. <https://doi.org/10.1093/intqhc/mzm042>
24. Kurtz S, Silverman J, Benson J, Draper J, Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge guides. *Acad Med* 2003;78(8):802-809. <https://doi.org/10.1097/00001888-200308000-00011>
25. Interprofessional Education Collaborative Expert Panel. Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel. Washington, DC: Interprofessional Education Collaborative, 2011.
26. Ngo-Metzger Q, Sorkin DH, Phillips RS, et al. Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. *J Gen Int Med* 2007;22(2):324-330. <https://doi.org/10.1007/s11606-007-0340-z>

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Appendix 1. Key competencies for the communicator role described in the University of KwaZulu-Natal College of Health Sciences core competencies framework^[14]

Communicator role:^[14] As communicators, healthcare professionals effectively facilitate the carer-patient/carer-client relationship and the dynamic exchanges that occur before, during and after interventions

Key competency 1: Develop rapport, trust and ethical therapeutic relationships with patients/clients, families and communities from different cultural backgrounds

Key competency 2: Accurately elicit and synthesise relevant information and perspectives of patients/clients, families, communities, colleagues and other professionals

Key competency 3: Convey relevant information and explanations accurately and effectively to patients/clients, families, communities, colleagues and other professionals, as well as statutory and professional bodies

Key competency 4: Develop a common understanding of issues, problems and plans with patients/clients, families, communities, colleagues and other professionals to develop a shared plan of care/action

Key competency 5: Convey effective and accurate oral and written information about a client encounter

Core competencies: Attitudes, skills and knowledge that students should develop by the time they graduate from an academic programme in the health sciences. These competencies are not subject or discipline specific; rather, they are central qualities necessary to enable students to use effectively the knowledge that they have gained

Key competencies: Any of several generic competencies considered essential for graduates to participate effectively in the workplace