The Communication Tool Belt Defined
Lindy H. Landzaat DO & Karin Porter-Williamson MD
Version 1.1

The Communication Tool Belt is a categorized description of communication elements. The intent of this Tool Belt description is to provide a shared vocabulary for the advancement of communication skills with the ultimate goal of creating meaningful, safe dialogue.

1) Physical Tools: How one uses their self, space, environment, and others to facilitate communication.

a) Location: Where is the communication occurring? What environmental factors such as distractions are present? Has the location been optimized? Could be in person, telephone, video chat, etc.
b) Body language: Recognition of the impression that one may intentionally or unintentionally communicate to others via their body positions during a communication interaction.
c) Arrangement: How the space and participants are positioned within a location. This might include but is not limited to space relative to one another, to the patient, or their stance (Sitting, standing?) Where are the tissues?
d) Mirroring: Choosing consciously or subconsciously to exhibit similar non-verbal or verbal communication characteristics as those with whom one is engaged in communication.
e) Appearance: Recognition that physical ways that one presents themselves to others creates impressions. Some aspects of physical appearance may be intentional or not. To wear a white coat or not? To let the hair grey a bit or not?
f) Attendees: The persons present for the communication encounter. Are the appropriate parties present or represented for the communication encounter?

2) Emotional Tools: How one interacts and responds to emotions to facilitate communication

a) Empathy: An attempt to accompany another person in their suffering
b) Rapport: The level of trust and comfort the patient has for another, typically accumulated over time.
c) Active Listening: Exhibiting signs that communication was received.
   (1) Therapeutic Presence: Assuming a presence that is desired and helpful
   (2) Echoing: repeating back a piece of the communication to show it was received, or to further an understanding, e.g. “so I hear you saying…”
d) Silence: Lack of verbal communication. Can often be used intentionally to convey respect, patience, and often a component of therapeutic presence, can allow enough “space” for the patient and family to reflect and respond
e) Naming an emotion/action: The receiver of communication identifies and labels a feeling, action, or idea. “What you are describing sounds like disbelief.”
f) Normalize: When someone identifies an occurrence as an expected part of a process. “This type of breathing is expected in dying patients”
g) Validate: When one provides support or substantiation to an idea, feeling, emotion in its context.
h) Rationalizing: Offering an explanation for an occurrence/event.
i) De-escalation: Employing strategy or skills to remove intensity or tension from a situation. Examples might include allowing another to vent, finding a common purpose, setting boundaries.

j) Touch: physical contact with another to display meaning, such as emotional support

k) Self monitoring: real-time reflecting about one’s own emotional and physiologic arousal. Self monitoring requires an awareness of one’s tendencies within conversation, particularly when intense.

3) Cognitive Tools: Skills to facilitate patient and family understanding

   a) Barrier Identification: Recognizing factors that create impediments to understanding and effective communication.
   i) Knowledge deficits—patient/family has not effectively received requisite information. This may be a result of incomplete information provided, impaired understanding, or inability to process information. Sometimes different coping mechanisms serve as a barrier to processing information.
   ii) Language barriers—a discrepancy between languages spoken complicates effective communication
   iii) Cultural barriers—Differences in interpretations and actions as a result of diverse backgrounds, values, and/or beliefs.
   iv) Psychosocial barrier—effective communication is challenged by a psychological factor, social, or socioeconomical factor. For example: pt is unwilling to fully disclose information with loved ones present; a family member is unavailable for bedside discussions due to transportation challenges.
   v) Learning disabilities—patient/family may have difficulty processing information in a particular way
   vi) Hearing disabilities—communication may be challenged to hearing impairment
   vii) Visual disabilities—communication may be challenged due to vision impairment

b) Teaching: Methods used to convey information
   i) Interpretation of medical language—translating medical language or concepts into “normal English”, understandable for non-medical individuals.
   ii) Visual aids—Using drawings, diagrams, models or other visual media to enhance understanding
   iii) Analogy/metaphor—Using analogy or metaphors to facilitate understanding
   iv) Gestures—using body language and motion to attempt to convey understanding
   v) Framing—Offering an overview or context for an idea, concept, or agenda. “We are meeting today to discuss…”
   vi) Reframing—Suggesting an alternative overview or context for an idea, concept, or agenda.

   c) Understanding Checks (with patient, family, or other medical professionals in an interaction):
   i) Summarize—providing synopsis of communication
   ii) ‘Take one for the team’ clarification—Asking a clarification or strategic question of another medical provider with the hopes of facilitating another’s understanding (patient/family/learner). Sometimes it may be a question the family is struggling to ask for themselves, sometimes it is to more effectively communicate the message. “Doctor, am I hearing you correctly that the goals of this medication is to help shrink the cancer, but it is, unfortunately, not curable?”
   iii) Request questions—Intentionally seeking questions as method to check level of comprehension and to normalize that questions may persist. “What questions do you have?”
   iv) Request a teach-back—Soliciting a patient or family’s comprehension by asking them to repeat back what they understand of a communication, concept, set of instructions, etc.
4) **Orchestration Tools-Skills used to conduct and promote effective communication interactions**—

a) **Atmosphere**—the ambiance created in the communication venue. Often created by multiple factors such as physical location, tone, framing, etc.

b) **Mode**—the method used in order to achieve shared communication
   i) **Verbal**: using sound to communicate
   ii) **Written**: Using writing to communicate messages
   iii) **Open or Close Ended Questions**: Open ended questions are intended to create the need for a more detailed answer. Close ended questions are intended to be answered with a simple reply.
   iv) **Yes or No questions**: A type of close-ended question; sometimes necessary when lengthier responses are not understandable or desired.
   v) **Intentional Body Movement Communication**: Communication sometimes used when verbal or written communication is not possible. Examples include, lip reading, eye movements, intentional hand squeezes.

c) **Approach**—the manifestation of control between two communicators
   i) Paternalistic: “owning” the control, directing
   ii) Passive: deferring to others, may range from accommodating to avoiding
   iii) Aligning: Partnering or allying with others
   iv) Neutral: indifference to competing outcomes/control

d) **Delivery**—the way information is conveyed to another
   i) **Titration of Information**: the adjusted amount and complexity of information communicated. Can range from simple to detailed. May require repeated information provided over time.
   ii) **Organization**—The way in which one communication of one element or action follows another. Examples include tangential, random, linear
      (1) **Prioritizing**—recognition that some communications or needs may be more important than others at a given point in time
   iii) **Tempo**—the speed and cadence of a communication encounter
      (1) **Rate**—the speed at which communication occurs
      (2) **Rhythm**—the flow of communication set in part by the rate and periodic breaks (intended or natural) in a communication.
         (i) **Pauses**—breaks in communication that may be silent or with verbal fillers, (e.g. uh-huh).
         (ii) **Interrupting**—may be intentional or not, the breaks that stop the current communication and prioritize a different one.
         (iii) **Redirecting**—using a transition statement to reroute, guide or steer the conversation to a new communication topic or point.
   iv) **Manner**—The style of information sharing. This can occur on a spectrum from a gentle or soft to a harsh or blunt sharing of information. Akin to ‘bedside manner’. The manner may change between different communication encounters or within the same communication encounter.