



FROM INTENT TO IMPLEMENTATION

A Blueprint for Elevating Clinical Communication Competency in Undergraduate Medical Education in India

Released in New Delhi on 20 September 2026

SIG Clinical Communication

In association with ICAIM and DoctorsAI

Knowledge & Implementation Partner: SigmaMozak Solutions

Why was the Blueprint developed?

Clinical communication is already present within undergraduate medical education, but the national consultation suggests that implementation is often fragmented.

The current consultation dataset shows:

- **76%** of respondents report structured communication training across most or all MBBS phases.
- Yet only **4%** report using an integrated longitudinal record to guide individual learner feedback and progression.

The challenge is therefore not simply adding more communication teaching. It is creating a system in which communication competency can be practised repeatedly, observed, assessed, documented and progressively strengthened across the learner journey. The Blueprint was developed to help move that discussion from curricular intent to practical implementation.

The Blueprint was developed from the consultation analysis frozen for the September 20 advisory session (145 institutions). The consultation has since expanded to 147 unique institutions across 31 States and Union Territories.

WHAT THE BLUEPRINT ADDRESSES

1. Longitudinal learning rather than isolated sessions

Communication competency should develop across phases of medical education rather than through disconnected activities.

The Blueprint therefore places emphasis on:

- repeated practice;
- progression across phases;
- continuity between departments;
- feedback over time; and
- opportunities to demonstrate improvement.

2. Practical assessment and feedback

Institutions need feasible ways to assess communication consistently.

The national consultation found that 49% of respondents identified standardised assessment rubrics and OSCE stations as a priority support need.

The Blueprint therefore considers:

- Practical assessment frameworks;
- Structured observation;
- Feedback approaches;
- Reassessment;
- Learner progression; and



- Longitudinal competency documentation.

3. Faculty and Medical Education Unit support

Implementation depends on faculty capacity. Respondents identified large student-to-faculty ratios, limited faculty time, faculty-development needs and cross-departmental coordination as important challenges.

The Blueprint therefore proposes a stronger implementation role for:

- Faculty-development programmes;
- Medical Education Units;
- Cross-departmental coordination;
- Shared teaching resources; and
- Practical implementation guidance.

4. Shared case and session resources

Institutions should not need to independently recreate every communication-teaching activity. 45% of respondents identified case and session resources as a priority need.

The Blueprint therefore supports development of adaptable resources that can be used across institutions while allowing local contextualisation.

5. Student participation

Communication education should not be designed solely around institutional processes.

Students need opportunities to contribute to how communication is:

- Taught;
- Practised;
- Experienced;
- Assessed; and
- Improved.

Student engagement is therefore intended to remain part of the SIG's implementation and research programme.

6. India's multilingual clinical reality

Clinical communication in India frequently occurs across languages, dialects and varying levels of health literacy. The Blueprint recognises that communication competency cannot be treated solely as an English-language educational exercise.

Future work will therefore explore:

- Multilingual clinical terminology;
- Language-sensitive communication;
- Voice-enabled approaches;
- Simulation across languages; and
- Appropriate applications of language technology.

7. Research and evidence generation

Implementation should be evaluated, not assumed to work. The Blueprint places emphasis on generating evidence around:

- Learner outcomes;
- Faculty experience;
- Feasibility;



- Implementation fidelity;
- Institutional adoption;
- Assessment reliability;
- Patient-centred communication outcomes; and
- Technology-supported approaches.

8. The role of technology

Technology is included as an **enabler**, not as the centre of the Blueprint.

Potential applications include:

- Simulated practice;
- Structured feedback;
- Learner-level progression tracking;
- Faculty visibility;
- Multilingual support; and
- Scalable practice opportunities.

ConversationAlly was demonstrated during the National Advisory Session as one potential technology-enabled response to some of these challenges. The Blueprint does not position any single technology as the solution to clinical communication education.

WHAT THE BLUEPRINT IS NOT

The Blueprint is **not**:

- A regulatory guideline;
- An NMC mandate;
- A Government of India standard;
- A requirement for medical colleges;
- A single prescribed curriculum;
- A technology deployment plan; or
- Evidence that participating institutions have formally adopted its recommendations.

It is an implementation-focused framework for collaborative development, testing and evidence generation.

WHAT HAPPENS NEXT?

The Blueprint now provides a structure for the SIG's next phase of work.

Priority areas include:

Expert workstreams

to develop practical solutions around assessment, implementation and teaching resources.

Faculty development

to strengthen institutional capacity for teaching and feedback.

Case and session resources

that can be adapted across medical colleges.

Assessment tools

including rubrics, OSCE approaches and longitudinal feedback methods.

Student engagement

to ensure learner experience informs programme development.



Multilingual clinical communication

to address India's real-world linguistic context.

Institutional pilots

to test feasibility and implementation models in diverse settings.

Research and evaluation

to build evidence around what works, for whom and under what conditions.

THE PRINCIPLE BEHIND THE BLUEPRINT

The objective is not simply to ensure that communication appears in the curriculum.

It is to create conditions in which communication competency can be: taught → practised → observed → assessed → fed back → reassessed → progressively developed throughout undergraduate medical education.

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