



SIG
CLINICAL
COMMUNICATION
Advancing Medical Education and Training
in Clinical Communication

FROM INTENT TO IMPLEMENTATION

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



NATIONAL CONSULTATION
Findings and Implementation
Framework

2026

PEOPLE.
PRACTICE.
POSSIBILITIES.

FOREWORD

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Chairperson · Special Interest Group on Clinical Communication

Clinical communication is central to the practice of medicine. It shapes how patients describe their concerns, how clinicians understand illness in context, how decisions are explained and negotiated, and how treatment plans are ultimately understood and acted upon. Indian undergraduate medical education has already recognized this through the competency-based curriculum and the AETCOM framework, which established communication as an explicit educational responsibility.

The next challenge is implementation.

Across medical colleges, communication is being taught through role-play, small-group learning, bedside encounters, simulation, reflective exercises and formal assessment. Yet the development of communication competency requires more than the presence of these activities. Learners need repeated opportunities to practice, receive meaningful feedback, demonstrate improvement and progressively apply communication skills in increasingly complex clinical situations.

The Special Interest Group on Clinical Communication under the Indian College of Artificial Intelligence in Medicine was formed to examine these implementation questions with medical educators rather than begin with a predetermined model. Its first major academic activity was therefore a national consultation with medical colleges.

The consultation received 148 submissions representing 145 unique medical institutions across 30 States and Union Territories. The findings demonstrate substantial existing effort, but also identify important gaps in longitudinal progression, faculty capacity, cross-department coordination, assessment resources and the use of learner information over time. They also show considerable willingness among institutions to participate in the next phase of collaborative development and evaluation.

This Blueprint brings together the rationale for the initiative, the findings of the national consultation, their implications for undergraduate medical education, the potential role of technology, and the academic work proposed for the next phase. It is not intended to create a parallel curriculum or prescribe a single implementation model. Its purpose is to provide a shared starting point for medical educators to develop, test and refine approaches that are academically sound, feasible within institutional realities and responsive to the diversity of clinical practice in India.

The work ahead will require collaboration across Medical Education Units, clinical departments, institutions, students, academic experts and implementation partners. The value of this Blueprint will ultimately lie not in the document itself, but in the quality of the academic work and evidence that follows from it.

Prof Avinash Supe

Chairperson

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148	submissions received
145	unique medical institutions
30	States & Union Territories

CHAPTER 1

Formation of the SIG and Need to Involve Medical Educators in Understanding the Problem

1.1 Clinical communication as a competency in undergraduate medical education

Clinical communication is not separable from clinical practice. The way a clinician elicits a patient's concerns, explains illness and treatment, responds to emotion, checks understanding, negotiates a plan and closes an encounter influences what information becomes available for decision-making and how that decision is subsequently understood and acted upon.

The behaviors involved are teachable and observable. They include establishing rapport; eliciting concerns, beliefs, fears and expectations before providing advice; recognizing and responding to emotional cues; explaining without unnecessary jargon; involving patients in decisions; avoiding stigmatizing or blaming language; and confirming understanding through techniques such as teach-back and safety-netting. These are not simply interpersonal attributes. In many consultations, particularly those involving chronic disease, treatment adherence, risk, uncertainty or sensitive decisions, they constitute an important part of the clinical work itself.

Indian undergraduate medical education has already taken an important step in recognizing this. The competency-based undergraduate curriculum and the Attitude, Ethics and Communication framework (AETCOM) established communication as an explicit educational responsibility rather than an attribute presumed to develop informally during clinical exposure. Communication is expected to be taught, practiced and assessed as part of the development of the Indian Medical Graduate.

The educational question therefore extends beyond whether communication appears in the curriculum. A competency is demonstrated in performance. Knowing the principles of an effective consultation, participating in a classroom discussion or completing a reflective exercise does not necessarily establish that the learner can recognize a patient's cue, elicit a concern, respond appropriately and reach shared understanding during an actual clinical conversation.

For clinical communication, development is inherently iterative. Learners require opportunities to encounter different communication tasks, perform them, receive feedback, reflect and return to comparable tasks with increasing independence. The required behavior also changes with context. Explaining a new diagnosis, discussing poor adherence, obtaining informed consent, responding to fear, communicating uncertainty and breaking difficult news cannot be reduced to a single generic communication exercise.

The challenge is consequently one of implementation as much as curriculum.

1.2 What was already known

Indian experience with AETCOM has generated evidence that structured teaching can improve communication-related outcomes. Studies considered during the SIG's evidence review reported improvement in communication scores following AETCOM training and favorable changes in student perceptions and attitudes after structured educational exposure. One multicenter study involving six medical colleges in Maharashtra and 240 students reported significant improvement in KEECC-A communication scores after training; another study among first-professional-year students reported improved perceptions following structured AETCOM sessions.

These findings support the educational value of structured communication teaching. They leave a different set of questions less well answered.

Much of the available Indian literature has been institution-specific, based on perceptions or short-term outcomes, and has rarely examined whether communication performance is followed longitudinally across phases of undergraduate training. Evidence that learners value communication training or improve immediately after an intervention is important, but it is not equivalent to evidence that the competency is repeatedly demonstrated, observed and developed across clinical contexts.

Implementation studies had also identified practical constraints before the SIG undertook its consultation. Faculty workload and preparedness, large student-to-

faculty ratios, infrastructure limitations and difficulties in assessment recur in the Indian CBME and AETCOM literature. The evidence review used during development of the national advisory work identified student-to-faculty ratio, infrastructure and assessment among the most frequently reported implementation constraints.

This matters because communication training is unusually dependent on observation and feedback. A lecture can be delivered to a large cohort. Individual communication performance is more difficult to observe at comparable scale. Repeated faculty observation of every learner, across multiple clinical contexts and over several years, creates a different educational and operational burden.

The implementation problem is therefore not adequately described by asking whether communication is being taught. It requires examination of the opportunities learners receive to practice; how frequently performance is observed; what form feedback takes; how assessment is standardized; whether deficits lead to further learning; and whether performance across encounters becomes part of a developmental record.

1.3 Evidence from patients and from observed learner performance

A second reason for examining implementation more closely came from research demonstrating that specific communication behaviors are consequential and measurable.

An analysis of 62,319 patient-generated physician reviews from 10 Indian cities and eight specialties examined communication dimensions derived from established clinical communication frameworks. In that corpus, reassurance and empathy were the strongest positive predictors of recommendation, while excessive directiveness and rushedness were prominent negative predictors. Directiveness was present in one-third of reviews expressing an intention to switch physicians. The analysis also found meaningful specialty variation, reinforcing that communication quality is both behavior-specific and context-dependent.

Patient evidence of this kind does not establish how communication should be taught. It does, however, strengthen the rationale for treating communication as observable clinical behavior rather than an abstract professionalism construct.

62,319

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1.4 Formation of the Special Interest Group on Clinical Communication

Against this background, the Indian College of Artificial Intelligence in Medicine (ICAIM), the academic wing of the DoctorsAI Education and Research Foundation, constituted the Special Interest Group on Clinical Communication as an academic forum bringing together medical educators, clinicians and implementation expertise around clinical communication competency in undergraduate medical education.

The SIG's purpose was to examine unresolved questions related to implementation: how institutions translate those expectations into repeated learning opportunities, meaningful observation, structured feedback, assessment and learner progression within the realities of undergraduate medical education.

The distinction was important from the outset.

Clinical communication training is delivered inside medical colleges, through Medical Education Units and multiple preclinical and clinical departments. Its feasibility is shaped by batch size, faculty availability, teaching schedules, assessment systems, simulation capacity, language, local patient populations and existing institutional practices. A framework developed without understanding these conditions would risk solving an assumed problem rather than the one institutions actually experience.

The SIG therefore adopted an enabling rather than prescriptive role. Its initial priorities were to understand how communication was currently taught, practiced, assessed and tracked; identify recurring implementation constraints; understand what forms of support institutions considered useful; and determine where further collaborative academic work was required.

1.5 Why the first step had to be a national consultation

The decision to begin with medical educators and institutions followed directly from the nature of the problem.

Published studies could indicate that particular interventions improved particular outcomes. A single-institution pilot could demonstrate that behavioral communication performance could be observed and that specific learner deficits might be identified. Neither could show how communication education was currently being implemented across the diversity of Indian medical colleges.

The SIG therefore chose not to begin by prescribing a model. Medical Education Units, institutional academic leaders and faculty involved in undergraduate teaching were asked to describe their current implementation rather than evaluate a proposed solution. The consultation was designed to examine where communication was being taught across the MBBS program; the teaching and learning approaches being used; assessment methods; longitudinal

documentation; faculty capability; practical barriers; forms of support considered useful; and institutional readiness for subsequent collaborative work. This was consistent with the SIG's stated intention to build an institution-grounded and evidence-informed framework rather than impose a uniform model from a small central group.

This approach also recognized that variability is not necessarily evidence of failure. Different institutions operate with different resources and have developed local approaches that may contain valuable solutions. A national consultation could therefore identify both constraints and existing practices worth examining more closely.

The aim was to move the discussion from assumptions about AETCOM implementation to an empirical description of what institutions were actually doing. The consultation that followed became the first major academic activity of the SIG.

Its methodology and findings are presented in the next section.

The implementation problem is not whether communication is taught. It is defined by the practice learners receive, how often performance is observed, and whether that performance becomes part of a developmental record.

CHAPTER 2

National Consultation: Methodology and Findings

2.1 Consultation design and scope

The National Consultation on AETCOM Implementation and Clinical Communication Training was designed as an institutional, cross-sectional consultation rather than as an individual faculty survey. Its purpose was to describe how medical colleges were currently operationalizing clinical communication education and to identify areas in which institutions themselves perceived a need for further academic or implementation support.

The consultation instrument was structured around the questions that had emerged during the formation of the SIG: the extent of implementation across the MBBS program; stages at which structured clinical communication teaching was occurring; protected teaching time; teaching and learning methods; assessment approaches; longitudinal documentation of learner competency; faculty preparedness; institutional confidence; implementation barriers; support requirements; and readiness for subsequent collaborative work. Respondents were also provided an optional free-text field to identify institutional experiences or implementation issues not adequately captured by the structured questions.

The survey was intended to obtain one coordinated institutional response from each medical college, preferably from a Dean, Principal, Medical Education Unit member, AETCOM lead or another faculty member with direct knowledge of undergraduate implementation. The consultation was explicitly positioned as an academic exercise rather than a regulatory survey. Institutions were informed that findings would be reported in aggregate and that colleges would not be publicly ranked on the basis of their responses.

Responses used a combination of single-choice and multiple-response items. For barriers and preferred forms of support, respondents were asked to select up to three priorities.

Consequently, percentages for these questions are not mutually exclusive and may sum to more than 100%.

2.2 Analytical dataset

The consultation received 148 submissions between 7 August and 14 September 2026. Following institutional cleaning and deduplication, these represented 145 unique medical institutions across 30 States and Union Territories. Where more than one response had been received from the same institution, the latest institutional submission was retained for institution-level analysis.

Accordingly, the denominator for the principal findings presented in this Blueprint is $n = 145$ institutions. Percentages are rounded to the nearest whole number in the main text; the underlying analysis retains the unrounded values.

The participating institutions represented a broad range of organizational settings. 42% were government medical colleges, 33% private institutions, 15% deemed universities, and approximately 9% represented trust, society, autonomous, public-private or other institutional arrangements. The reported annual MBBS intake across the 145 institutions totaled 26,347 students per year.

The consultation also reached respondents positioned close to educational implementation. 68% of responses were submitted by Medical Education Unit coordinators or members and 20% by Deans, Principals or Directors. The remaining responses came from heads of department, AETCOM or curriculum leads and other faculty involved in undergraduate medical education. Thus, approximately 88% of responses came from MEU or senior institutional leadership roles.

Geographic participation was distributed across 30 States and Union Territories. Maharashtra contributed the largest number of participating institutions, followed by Karnataka, Tamil Nadu and Uttar Pradesh, with representation extending across government, private and deemed institutions in different regions of the country. The consultation should nevertheless be interpreted as a broad multi-institutional national consultation rather than a probability sample of all Indian medical colleges.

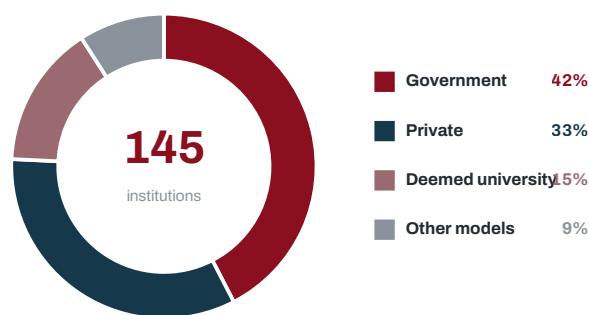


FIG 1 Institutional profile of the 145 participating institutions.

2.3 Current extent of implementation

The first important finding was that structured clinical communication education was already present in most responding institutions.

Forty percent described their implementation as fully integrated longitudinally across all MBBS phases with defined assessment, while a further 35% reported structured implementation across most MBBS phases. Taken together, 75% of institutions reported structured implementation across most or all phases of undergraduate training.

A further 18% reported structured implementation in one or two phases, 6% described activity as isolated or occasional, and only 1% reported that structured implementation had not yet been initiated.

The distribution across specific stages of training showed both breadth and some decline in later phases. Structured clinical communication teaching was reported during:

- Phase II: 82%
- Phase I: 79%
- Foundation Course: 75%
- Phase III Part I: 74%
- Phase III Part II: 68%
- Internship: 40%
- Elective or enrichment programs: 26%

Only 3.5% reported no structured teaching at any of the stages listed.

Protected teaching time was considerably less uniform. Forty-one percent reported that the number of protected hours varied substantially by phase. Among institutions providing a more stable estimate, 22% reported more than 20 hours per academic year, while the remainder were distributed across 1 to 5 hours, 6 to 10 hours and 11 to 20 hours.

The consultation therefore captured a system in which communication teaching was widely present, but the amount and continuity of structured exposure differed considerably across stages.

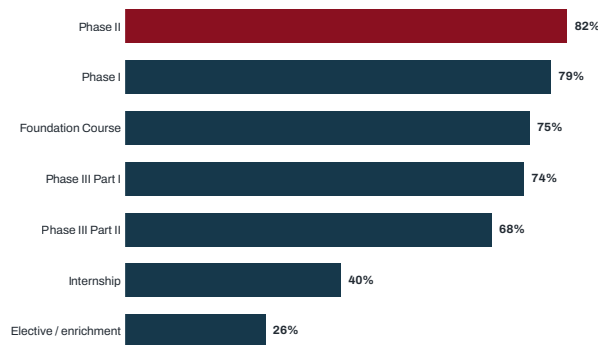


FIG 2 Structured teaching by stage of training (percentage of institutions).

2.4 Teaching and learning approaches

The reported pedagogy was not predominantly lecture-based. Active and experiential approaches were already widely used.

Small-group discussion and student-to-student role-play were each reported by 86% of institutions. Observed bedside or outpatient interaction was used by 72%, reflective writing or portfolio activity by 60%, and didactic or large-group teaching by 60%.

Simulation was also established in a substantial proportion of institutions. Fifty-seven percent reported the use of standardized or simulated patient encounters. Video-recorded encounters with feedback were reported by 34%, peer feedback by 29%, and digital or virtual-patient simulation by 23%.

These results are important descriptively because they show that many institutions have already moved beyond a purely didactic model of communication education. At the same time, approaches that make performance repeatedly recordable and available for structured feedback were considerably less widespread than role-play, small-group teaching or conventional simulated encounters.

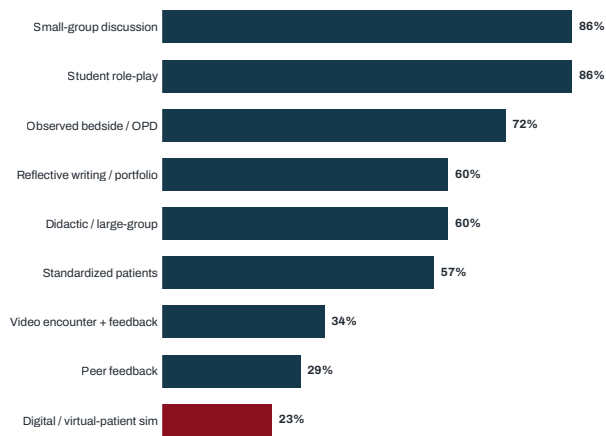


FIG 3 Teaching and learning methods in use.

2.5 Language of training

The current language of structured AETCOM training was overwhelmingly English.

Ninety-four percent of institutions reported English as the principal language of training, compared with 4% reporting a regional or local language and 1% reporting Hindi.

This item measured the language in which training was delivered, not the language used in clinical encounters with patients. The distinction is important. The finding does not indicate that patient communication occurs predominantly in English; it indicates that formal communication education is currently delivered largely through English-language teaching environments.

2.6 Assessment is widespread

Formal assessment of clinical communication was reported by most institutions, frequently through more than one method.

The most commonly reported approach was the OSCE or OSPE station, used by 81% of institutions. Written examinations or case-based questions were used by 71%, reflective portfolios or logbooks by 67%, and directly observed clinical encounters by 58%.

Workplace-based assessment was reported by 41%, while 18% incorporated patient feedback and 8% used video-based review.

The consultation therefore did not identify an absence of communication assessment. On the contrary, structured assessment methods were already extensively used across participating institutions.

A different pattern emerged when institutions were asked what happened to individual learner information over time.

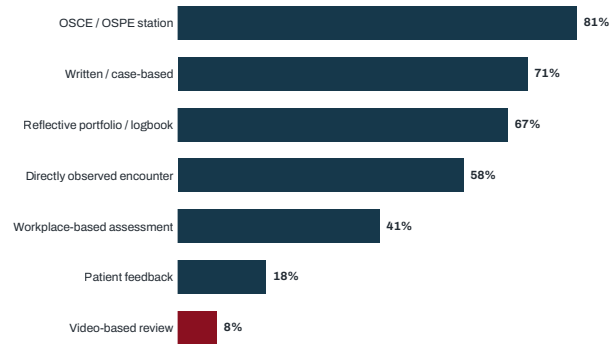


FIG 4 Assessment methods in use.

2.7 Longitudinal documentation remains uncommon

Half of the institutions reported using a portfolio or logbook carried across multiple phases. A further 29% maintained records within individual phases or departments.

However, these forms of documentation were rarely being used as an integrated developmental record. Only 4 of 145 institutions, approximately 3%, reported an integrated longitudinal record used specifically to guide feedback and progression.

Elsewhere, 10% reported isolated scores or attendance records and 9% reported no individual documentation of communication competency.

The contrast is substantial: 81% reported using OSCE or OSPE stations, but only 3% reported a longitudinal record that linked performance to subsequent feedback and progression.

This distinction between recording activity and using information developmentally becomes important in interpreting the consultation and is examined further in Section 3.

2.8 Faculty preparation and institutional confidence

The consultation did not suggest that participating institutions lacked exposure to faculty development.

Sixty-one percent reported that more than 20 faculty members had received relevant training in communication-skills teaching or assessment. A further 13% reported 11 to 20 trained faculty, 12% reported 6 to 10, and 12% reported 1 to 5. Only 3% reported no faculty with relevant training.

Institutional confidence was also relatively high. Thirty-one percent described themselves as extremely confident that they could deliver and assess clinical

communication consistently, and 54% as somewhat confident. Approximately 14% were neutral and 1% somewhat not confident.

Thus, around 85% of institutions expressed at least some confidence in their capacity to deliver and assess communication education, even though substantial implementation barriers were reported elsewhere in the consultation.

2.9 Principal implementation barriers

When institutions were asked to select the three most important barriers to consistent implementation, one constraint was markedly more frequent than the others.

Large student-to-faculty ratio was selected by 65% of institutions.

The next most frequently selected barriers were:

Difficulty coordinating across clinical departments: 35%

Insufficient protected curriculum time: 35%

Limited number of trained faculty: 29%

Difficulty maintaining longitudinal learner records: 29%

Insufficient faculty time: 29%

Lack of practical assessment tools or rubrics: 22%

Lack of standardized cases or teaching resources: 17%

Limited digital infrastructure: 15%

Limited access to simulated patients or skills-laboratory resources: 11%

Budget constraints were selected by 6%, while limited institutional leadership support was selected by only 1%.

Because respondents could select up to three barriers, these percentages represent the frequency with which each issue was prioritized, rather than mutually exclusive categories.

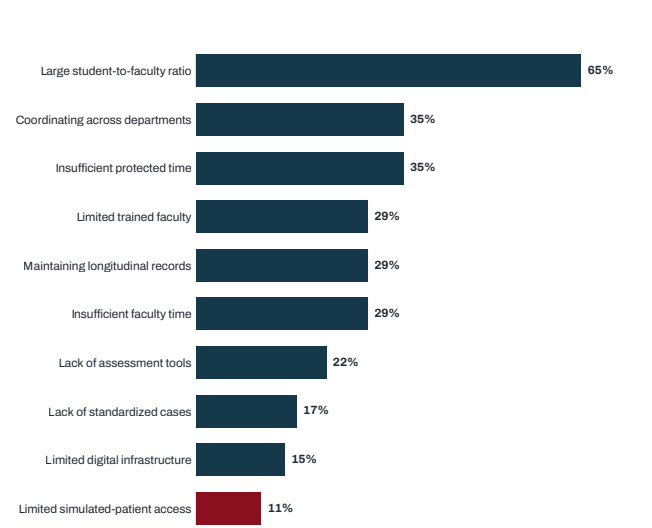


FIG 5 Most-cited implementation barriers.

2.10 What institutions said would help

The support priorities were correspondingly practical.

The most frequently requested resource was a standardized assessment rubric and OSCE stations, selected by 50% of institutions. This was followed by an AETCOM-aligned case and session library (45%), a faculty-development program (44%), and an implementation guide for Medical Education Units (42%).

Other requested forms of support included:

Simulated-patient or virtual-patient infrastructure: 31%

Longitudinal competency portfolio: 26%

Peer-learning network among medical colleges: 24%

Student-level feedback reports: 18%

Institutional dashboard and benchmarking: 13%

Research and publication support: 6%

Again, institutions were asked to identify up to three priorities. The support question was deliberately framed around what institutions considered useful for strengthening implementation rather than around endorsement of a predefined intervention.

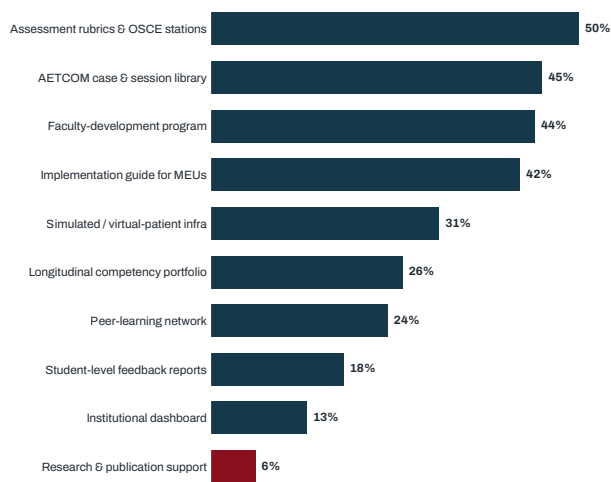


FIG 6 Most-requested forms of support.

2.11 Readiness for further institutional work

The consultation also asked institutions to characterize their readiness to participate in a structured, academically governed clinical communication pilot during the following 12 months.

Twenty percent reported that they were ready to begin within six months. Thirteen percent could begin within 6 to 12 months with limited support. The largest group, 44%, indicated that they could participate if teaching resources and faculty support were provided. A further 12% reported that they were already running a comparable structured program.

Taken together, 89% of responding institutions were either already engaged in comparable work, ready to begin, or potentially able to participate with varying levels of support.

Nine percent were interested but reported major capacity gaps that would prevent participation, while 2% indicated that such work was not a current institutional priority.

This readiness measure should not be interpreted as a commitment to participate in a specific future study or platform. It indicates institutional self-reported preparedness or interest in further structured work under different levels of support.

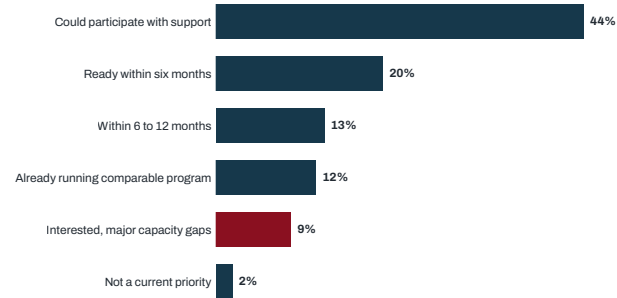


FIG 7 Institutional readiness for further structured work.

2.12 Interpretation limits

The consultation provides a large, geographically dispersed institutional dataset, but its methodological limits are important.

Participation was voluntary and the responding institutions were not selected through probability sampling. The findings should therefore not be described as nationally representative prevalence estimates for all medical colleges in India. They describe the practices and priorities reported by the 145 participating institutions.

The responses were institutional self-reports and were not independently verified against timetables, assessment records, faculty rosters or learner portfolios. Terms such as “fully integrated” reflect the response category selected by the institution and should not be interpreted as an independently audited measure of curricular quality.

Similarly, reporting that an assessment method is used does not establish its frequency, reliability or educational quality. Reporting a portfolio across phases does not establish that portfolio information is used to make developmental decisions. The consultation was designed to map implementation patterns and identify questions requiring deeper academic work, not to rank colleges or determine regulatory compliance.

The optional institutional comments add context to the quantitative findings and are considered alongside the response patterns in the following section.

CHAPTER 3

What Medical Colleges Are Telling Us

The national consultation suggests that the principal challenge is no longer whether clinical communication is present in undergraduate medical education. In most participating institutions, it is. Teaching is occurring across multiple phases, active learning approaches are common, and communication is being assessed.

The more important issue is whether these activities operate as a coherent system of competency development.

3.1 Presence does not necessarily mean progression

Communication teaching may occur repeatedly across the MBBS program without necessarily forming a developmental sequence.

A learner may participate in a role-play in one phase, complete an OSCE station in another, encounter bedside communication teaching during a clinical posting, and maintain a logbook across subsequent phases. Each activity may be educationally appropriate. The unresolved question is whether later learning deliberately builds on earlier performance.

For clinical communication to function as a competency, expectations should become more complex as the learner advances. Early training may emphasize opening an encounter, listening and eliciting concerns. Later training should extend to uncertainty, shared decision-making, treatment adherence, emotionally difficult conversations, risk communication and safe closure.

3.2 Assessment is occurring, but its developmental value is limited

The strongest implementation gap lies between assessment and the use of assessment information over time.

OSCE or OSPE assessment was reported by 81% of institutions, yet only about 3% reported an integrated longitudinal record specifically used to guide feedback and progression. This contrast matters more than the absolute number of assessments conducted.

The educational requirement is therefore not simply additional assessment. It is to connect assessment, feedback, subsequent practice and reassessment so that information from one encounter influences what happens next.

This also changes the purpose of documentation. A logbook or portfolio should ideally do more than confirm completion. It should help make development visible to the learner and to the faculty responsible for guiding progression.

3.3 Clinical context should vary, but expectations should remain coherent

Clinical communication is distributed across departments. This is appropriate because the communication task changes with the clinical situation. A pediatric consultation, psychiatric interview, surgical consent discussion and chronic-disease review should not use identical scenarios or scripts.

At the same time, the learner should encounter recognizable educational expectations across these settings: listening, eliciting the patient's perspective, responding to emotion, explaining clearly, avoiding stigmatizing or blaming language, involving patients appropriately in planning, checking understanding and closing safely.

The implementation challenge is therefore not to standardize the conversation itself. It is to create sufficient consistency in the competencies being developed and assessed.

3.4 Faculty capacity has to shape the implementation model

The consultation also makes clear that communication education cannot be designed as though faculty observation time were unlimited.

Large student-to-faculty ratios were the most frequently reported implementation barrier. Communication teaching becomes particularly resource intensive when learners require repeated observation, individualized feedback and reassessment across several years.

This has two implications.

Any national model that depends on faculty directly observing every practice encounter will be difficult to sustain at scale.

Faculty expertise should be concentrated where it contributes most: interpreting performance, coaching, addressing complex or sensitive communication, reviewing persistent difficulties and making academic judgments.

The implementation question is therefore how to increase opportunities for meaningful practice and feedback without weakening faculty oversight.

3.5 Institutions are asking for infrastructure rather than another curriculum

The pattern of requested support is also instructive. Institutions prioritized assessment rubrics and OSCE resources, case and session libraries, faculty development, and practical guidance for Medical Education Units.

These requests suggest that colleges do not primarily need another statement explaining why communication matters. Nor do they necessarily need a parallel curriculum outside AETCOM. They need resources that make implementation easier to organize and more consistent.

One participating institution expressed this directly:

“Need to integrate AETCOM into the existing curriculum rather than deliver content as standalone modules.”

Participating institution · National Consultation 2026

The implication is that future work should strengthen the infrastructure around existing curricular expectations: shared cases, common assessment principles, faculty preparation, longitudinal records and mechanisms for coordination across departments.

3.6 The consultation defines the requirements for the next phase

Taken together, the consultation identifies a relatively clear implementation agenda.

The next phase should help institutions move from isolated educational activities toward a connected cycle of practice, observation, feedback, improvement and reassessment. It should allow communication competency to become progressively more demanding across training, while remaining feasible for large cohorts and different institutional settings.

It should also address multilingual clinical communication explicitly. The finding that formal training is overwhelmingly delivered in English does not describe the language of patient care, but it does raise an important question about whether learners are being prepared for the multilingual and code-switched consultations they will encounter in practice.

Finally, the high level of institutional readiness for further collaborative work provides an opportunity to test these ideas across diverse medical colleges rather than developing them entirely through expert opinion.

The next question is whether technology can support some of these requirements alongside faculty judgment, clinical context or academic governance.

Presence is not progression. Communication is taught, but its development is rarely tracked across the phases of training.

CHAPTER 4

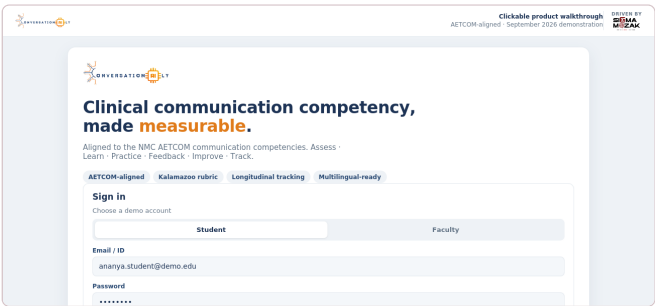
Can Technology Support the Implementation of Clinical Communication Competency? Potential Promise of ConversationAlly

4.1 The promise of technology

The national consultation identifies a practical implementation challenge: communication competency requires repeated practice, feedback and reassessment, but faculty time is constrained and longitudinal tracking is uncommon. Technology may help by expanding opportunities for simulated practice, providing structured formative feedback, retaining learner performance over time and allowing faculty to focus their effort on interpretation, coaching and remediation. Its role should be supportive rather than substitutive, with academic standards and competency decisions remaining under faculty and institutional governance.

4.2 Complementary technologies for clinical communication training

Several technologies can support components of clinical communication training, including simulation platforms, virtual patients, recorded consultation review, digital portfolios and emerging speech and language analytics. One platform that has drawn the SIG's attention is ConversationAlly, because it attempts to bring several of these functions together within a single longitudinal learning pathway linking practice, feedback, reassessment and progression.



SCREEN 1 Student entry, aligned to the NMC AETCOM competencies.

4.4 Evidence generated so far

Two medical-education studies have informed development.

4.3 What is ConversationAlly?

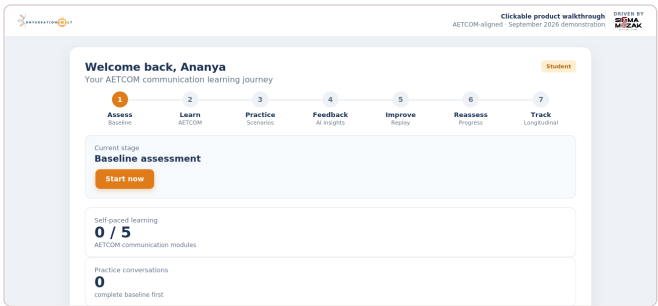
ConversationAlly is an AI-enabled clinical communication platform developed by SigmaMozak Solutions to make clinical discourse observable and available for structured feedback. It analyzes features such as lexical choice, stigmatizing language, directive versus collaborative phrasing, clarity, affective acknowledgement and conversational balance.

The underlying aim is to move feedback from broad judgments such as "be more empathetic" toward specific behaviors that learners can recognize and improve.

The platform has progressively evolved from a discourse-analysis and cueing tool into a medical-education environment built around the learner pathway:

Assess → Learn → Practice → Feedback → Improve → Reassess → Track

The current prototype includes AETCOM-linked learning modules, simulated consultation cases, baseline and reassessment reports, longitudinal learner records and faculty and MEU views. These remain developmental components and are not proposed as substitutes for faculty assessment.



SCREEN 2 Learner pathway: Assess, Learn, Practice, Feedback, Improve, Reassess, Track.

At the American Diabetes Association Scientific Sessions 2025, ConversationAlly was evaluated among 20 endocrinology residents. Ten residents used person-centered language cues during consultations

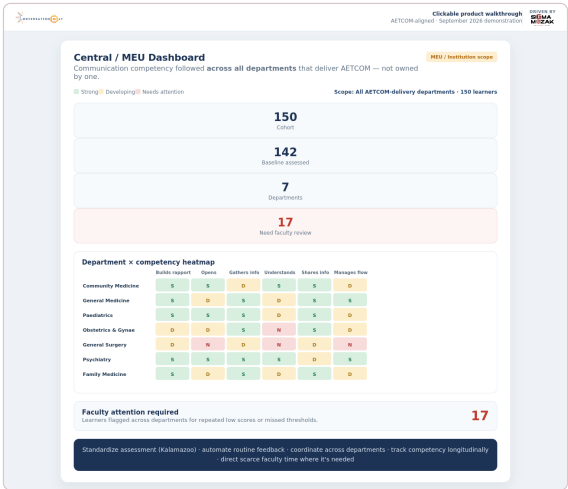
with people with type 2 diabetes and obesity. All ten reported that the tool helped them use person-centered language and avoid stigmatizing terminology; patient feedback also favored the intervention group. This small formative study demonstrated feasibility and acceptability, but was not designed to establish educational effectiveness.

A subsequent IEC-approved pilot at IMS & SUM Hospital, Bhubaneswar, examined undergraduate use of simulated consultations. Among 123 registered Phase III Part I MBBS students, 89 completed at least one consultation, generating 383 unique simulated sessions. After quality screening, 30 transcripts were selected for duplicate faculty review and 29 were analyzable by both raters. The exercise showed that

communication encounters could be captured asynchronously and subsequently reviewed by faculty at cohort level.

Faculty scoring also identified specific learning needs rather than a generalized communication deficit. Performance was strongest for stigma-free language and weaker for eliciting patient concerns and beliefs and for teach-back and safety-netting. Faculty agreement on the seven-domain rubric was very high. An exploratory comparison between automated and faculty scores also showed strong directional concordance, although the sample was too small to constitute formal validation of automated assessment.

Together, these studies provide formative evidence for feasibility and further evaluation.



SCREEN 3 Central / MEU dashboard: competency followed across all departments that deliver AETCOM.

4.5 What the national consultation has changed

The consultation has helped define what the next version of the platform needs to address.

The strongest institutional signals were the need to work within large student-to-faculty ratios, provide shared cases and assessment resources, improve faculty support, strengthen MEU coordination and create meaningful longitudinal records.

These findings have shifted ConversationAly from a stand-alone communication-analysis tool toward an implementation environment linking repeated practice, common assessment domains, learner progression and institutional oversight.

The consultation has also reinforced two design requirements. First, multilingual clinical communication must be treated as a development and validation problem rather than assumed to be solved.

Second, faculty judgment must remain central, particularly where automated outputs may eventually contribute to consequential decisions.

The detailed implications are highlighted in the table below.

National consultation signal	Implication for the developing platform
65% identify large student-to-faculty ratio as a major barrier	Increase opportunities for asynchronous learner practice and first-pass structured feedback, while reserving faculty time for interpretation, coaching and difficult cases
Only 3% report an integrated longitudinal record used for feedback and progression	Build a learner record that retains communication performance across repeated encounters rather than ending with isolated scores
50% request standardized assessment rubrics / OSCE stations	Use common communication domains and academically reviewed rubrics that can support comparable formative assessment
45% request case and session libraries	Develop a shared case library organized by phase, competency and clinical context
44% request faculty development	Incorporate faculty preparation for communication teaching, observation, feedback and interpretation of platform outputs
42% request an MEU implementation guide	Develop institutional and MEU workflows rather than treating the platform as a stand-alone learner application
Cross-department coordination is a major barrier for 35%	Create department-level and central/MEU views around common communication domains while preserving specialty-specific cases
English is the principal training language in 94% of institutions	Treat multilingual communication, translation, code-switching and cultural adaptation as areas requiring development and validation, not as solved capabilities
89% indicate an existing comparable program or potential readiness for structured pilots with varying levels of support	Move from single-institution feasibility work to academically governed multi-institution testing

4.6 Call for institutional pilots

The next step should be structured multi-institution evaluation, not broad adoption.

Institutional pilots should test whether the proposed model is educationally useful, feasible for large cohorts, acceptable to learners and faculty, and capable of supporting longitudinal development without creating disproportionate workload. They should also test agreement between automated and human assessment, transcript and data quality, multilingual performance, and appropriate governance.

ConversationAlly should therefore be positioned in this Blueprint as the initial digital implementation environment through which approved components can be integrated, piloted and evaluated.

Its eventual place in undergraduate medical education should be determined by the evidence generated through those institutional pilots.

CHAPTER 5

Taking the Work Forward: Academic Networks, Expert Collaboration and Institutional Evaluation

The national consultation provides a starting point rather than a final implementation model. The next phase of the SIG will focus on converting the priorities identified by medical colleges into academically reviewed resources, testing them across different institutional settings, and refining them through evidence.

The work will proceed through three connected mechanisms: expert workstreams, a continuing medical educator network, and multi-institution evaluation.

5.1 Expert workstreams

Four expert workstreams are proposed to develop the core components required for more coherent implementation.

Research and evidence generation will cut across all four workstreams. Multilingual clinical communication, faculty development and appropriate use of simulation and digital technologies will be addressed within and across these areas rather than developed as separate parallel programs.

The objective is not to prescribe identical teaching across medical colleges. A common academic core should coexist with adaptation to language, specialty, institutional resources and local clinical context.

Standardize the educational expectations. Preserve the authenticity of the clinical context.

Expert workstream	Principal focus
Institutional and MEU Implementation	Practical models for coordination across phases and departments, faculty development, workload, governance and implementation guidance
Clinical Communication Cases and Learning Resources	Shared cases and scenarios aligned with learner stage, clinical context and communication competency
Longitudinal Competency Integration	How communication development can be followed across phases rather than documented as isolated activities
Assessment and Feedback	Practical rubrics, formative assessment, faculty feedback and approaches to interpreting repeated performance

5.2 A continuing medical educator network

The institutions participating in the national consultation provide the foundation for a continuing network of medical educators, MEUs and faculty interested in clinical communication.

The network will allow draft cases, assessment tools and implementation resources to be reviewed against real institutional constraints before wider use. It will also provide a mechanism for colleges to share approaches that are already working locally.

The SIG website, Clinical CommEx newsletter, academic webinars, focused advisory discussions and institutional showcases can provide continuity between formal meetings and support dissemination of emerging resources and evidence.

5.3 Institutional pilots and collaborative research

Resources emerging from the expert workstreams should be tested through multi-institution pilots representing different cohort sizes, faculty capacities, languages and infrastructure.

Evaluation should focus on a small number of questions that matter for implementation:

Does the approach improve the intended communication competencies?

Can it be delivered within routine institutional systems?

What faculty time and support are required?

Is it acceptable and useful to learners and educators?

Can learner development be followed meaningfully over time?

Where technology is used, are its outputs sufficiently reliable and valid for the intended purpose?

The purpose of these pilots is to generate evidence and refine the model.

5.4 Governance and the next cycle of work

Academic standards should remain under educator and institutional governance. Institutions participating in research or technology-enabled pilots should retain appropriate authority over ethics, learner participation, data governance and academic decisions. Where commercial technologies such as ConversationAlly are evaluated, relevant interests should be transparently disclosed and technology-generated measures should be tested against independently defined academic standards.

The proposed development cycle is therefore straightforward:

Consult → Develop → Pilot → Evaluate → Refine → Share

The national consultation has established the problem and identified institutional priorities. The next phase is to determine, collaboratively, which approaches can be implemented, measured and improved across different medical-college settings.

THE CONTINUING CYCLE OF WORK

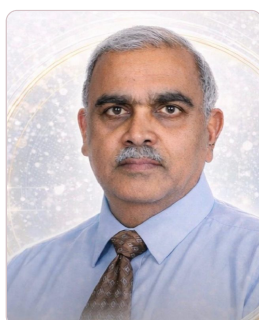


Common questions, common measures, locally appropriate implementation. The SIG becomes a continuing working network rather than a single consultation.

CHAPTER 6

SIG Leadership

The Special Interest Group on Clinical Communication brings together medical educators, clinicians, institutional leaders and implementation partners with complementary expertise in undergraduate medical education, faculty development, clinical practice, digital health, multilingual technologies and institutional innovation. The leadership group guides the academic direction of the SIG and the transition from national consultation to expert-led development, institutional pilots and collaborative research. The current leadership and advisory group includes the following members.



Prof Avinash Supe

CHAIRPERSON

Emeritus Professor of Surgical Gastroenterology and Medical Education, Seth GS Medical College, Mumbai.

Prof Supe provides academic leadership to the SIG, with particular focus on competency-based medical education, longitudinal development of clinical communication and ensuring that the initiative remains grounded in faculty stewardship and established principles of medical education.



Dr Meenal Mohgaonkar

CO-CONVENOR

Dean and Director Academics; Professor of Radiology, SMBT Institute of Medical Sciences & Research Centre, Nashik.

Dr Mohgaonkar contributes institutional and academic-governance expertise and has led the presentation and interpretation of the national consultation findings as the SIG moves from evidence gathering to academic development.



Dr Bidita Khandelwal

CO-CONVENOR

Professor and Head, Department of Medicine, Sikkim Manipal Institute of Medical Sciences.

Dr Khandelwal brings the perspective of clinical teaching and medical education, with particular emphasis on faculty capability, meaningful feedback and integration of communication competency into routine undergraduate clinical training.



Prof E. Venkata Rao

MEMBER

Professor, Department of Community Medicine, IMS & SUM Hospital, Bhubaneswar.

Prof Rao contributes the institutional implementation and research perspective to the SIG. His work with the undergraduate communication pilot at IMS & SUM has informed discussion around feasibility, faculty assessment, learner participation and the practical requirements of technology-enabled communication training.



Maj (Dr) Ashlesha Tawde-Kelkar

MEMBER

Associate Professor and Consultant Digital Health, CHAKRA, Government of Maharashtra.

Maj (Dr) Tawde-Kelkar brings experience in faculty and institutional capacity development, simulation and digital health. Within the SIG, her contribution is particularly relevant to translating communication competencies into sustained educational practice within medical colleges.



Dr Bhaskar Rajakumar

MEMBER

Chief Executive Officer, CHARAKA, Centre of Excellence in HealthTech & MedTech.

Dr Rajakumar contributes the perspective of institutional innovation, health-technology ecosystems and implementation. His role in the advisory work focuses on how educational innovations can move from experimentation through validation toward sustainable institutional adoption.



Shri Amitabh Nag

MEMBER

Chief Executive Officer, Digital India BHASHINI.

Shri Nag contributes expertise in multilingual digital infrastructure, speech and language technologies, terminology and language access. His participation brings the multilingual dimension of clinical communication into the SIG's academic work, including future questions around code-switching, voice-based learning and multilingual educational resources.



Ms Shweta Sharma

KNOWLEDGE & IMPLEMENTATION PARTNER

Founder and CEO, SigmaMozak Solutions, Hyderabad.

Ms Sharma leads the knowledge and implementation partnership supporting the SIG, including planning evidence synthesis, stakeholder coordination, implementation planning, translation of academic priorities into testable workflows, and development of ConversationAlly as a technology environment for structured practice, feedback and longitudinal learning. Academic standards and recommendations remain under SIG, expert and institutional governance.

CHAPTER 7

Institutional Association, Knowledge & Implementation Partner and Alliance Partners

The organizations associated with the SIG contribute different capabilities. Their participation should be understood in relation to those capabilities rather than as endorsement of any single educational or technology model.



CONVENED UNDER · ACADEMIC HOME

ICAIM and DoctorsAI Education & Research Foundation

The Indian College of Artificial Intelligence in Medicine (ICAIM) is the academic wing of the DoctorsAI Education and Research Foundation, focused on structured learning, research-led validation and collaboration at the interface of medicine and technology. The SIG is convened under ICAIM, which provides its academic home for the national consultation, advisory process and continuing educator network.

doctors-ai.org/icaim



KNOWLEDGE & IMPLEMENTATION PARTNER

SigmaMozak Solutions

A healthcare innovation and research company working across clinical practice, medical education, implementation science, real-world evidence and responsible technology; developer of ConversationAlly. This role does not confer academic authority over the SIG; academic standards and future recommendations remain subject to SIG, expert and institutional governance.

sigmamoza.com



ALLIANCE PARTNER

CHAKRA

A Section 8 organization under the Medical Education and Drugs Department, Government of Maharashtra, developing a state-level hub-and-spoke network of Centres of Excellence across medical education, faculty development, digital health, simulation and research. It brings relevance to faculty capability, institutional implementation and simulation.

chakra-coe.com



ALLIANCE PARTNER

CHARAKA, Centre of Excellence for HealthTech & MedTech

A Government of Karnataka Centre of Excellence for HealthTech, MedTech and the healthcare innovation ecosystem, connecting startups, government, industry and institutions. Its relevance lies at the interface between medical education and health-technology implementation.

charakacoe.org



ALLIANCE PARTNER

Digital India BHASHINI

The Government of India national language technology initiative under MeitY, using language technologies to reduce digital and language barriers across Indian languages. Its relevance extends beyond translation to terminology adaptation, code-switching and whether communication competencies remain valid across languages.

bhashini.gov.in

CHAPTER 8

Participating Medical Institutions

The Special Interest Group acknowledges the medical colleges that contributed institutional responses to the National Consultation on AETCOM Implementation and Clinical Communication Training.

148

submissions

145

unique institutions

30

States & UTs

- **Adesh Institute of Medical Sciences & Research**
Bathinda, Punjab
- **Adichunchanagiri Institute of Medical Sciences,**
Adichunchanagiri University
B. G. Nagara, Mandya, Karnataka
- **Agartala Government Medical College**
Agartala, Tripura
- **All India Institute of Medical Sciences, Bhubaneswar**
Bhubaneswar, Odisha
- **All India Institute of Medical Sciences, Bilaspur**
Bilaspur, Himachal Pradesh
- **All India Institute of Medical Sciences, Jodhpur**
Jodhpur, Rajasthan
- **All India Institute of Medical Sciences, Nagpur**
Nagpur, Maharashtra
- **All India Institute of Medical Sciences, Raebareli**
Raebareli, Uttar Pradesh
- **Alluri Sitarama Raju Academy of Medical Sciences**
Eluru, Andhra Pradesh
- **Andhra Medical College**
Visakhapatnam, Andhra Pradesh
- **Armed Forces Medical College**
Pune, Maharashtra
- **Army College of Medical Sciences**
New Delhi, Delhi
- **Autonomous State Medical College, Amethi**
Amethi, Uttar Pradesh
- **Autonomous State Medical College, Firozabad**
Firozabad, Uttar Pradesh
- **Baba Raghav Das Medical College**
Gorakhpur, Uttar Pradesh
- **Bhagat Phool Singh Government Medical College for Women**
Khanpur Kalan, Sonapat, Haryana
- **Bundelkhand Government Medical College**
Sagar, Madhya Pradesh
- **Burdwan Medical College**
Bardhaman, West Bengal
- **Byramjee Jeejeebhoy Government Medical College**
Pune, Maharashtra
- **Calcutta National Medical College**
Kolkata, West Bengal
- **Chhatrapati Sambhaji Maharaj Government Medical College**
Satara, Maharashtra
- **Chirayu Medical College & Hospital**
Bhopal, Madhya Pradesh
- **Christian Medical College**
Ludhiana, Punjab
- **Christian Medical College**
Vellore, Tamil Nadu
- **D. Y. Patil Medical College**
Kolhapur, Maharashtra
- **Dr. Chandramma Dayananda Sagar Institute of Medical**
Education and Research
Harohalli, Ramanagara, Karnataka
- **Dr. D. Y. Patil Medical College, Hospital and Research Centre**
Pimpri, Pune, Maharashtra
- **Dr. N. Y. Tasgaonkar Institute of Medical Science**
Karjat, Raigad, Maharashtra
- **Dr. Pinnamaneni Siddhartha Institute of Medical Sciences &**
Research Foundation
Chinna Avutapalli, Krishna District, Andhra Pradesh
- **Dr. Rajendra Gode Medical College**
Amravati, Maharashtra
- **Employees' State Insurance Corporation Medical College and**
Hospital, Noida
Noida, Gautam Buddha Nagar, Uttar Pradesh
- **Employees' State Insurance Corporation Medical College and**
Hospital, K. K. Nagar
Chennai, Tamil Nadu
- **Era's Lucknow Medical College & Hospital**
Lucknow, Uttar Pradesh
- **Faculty of Medicine and Health Sciences, Shree Guru Gobind**
Singh Tricentenary University
Gurugram, Haryana
- **Gajra Raja Medical College**
Gwalior, Madhya Pradesh
- **Gandhi Medical College**
Secunderabad, Telangana
- **Government Institute of Medical Sciences**
Greater Noida, Gautam Buddha Nagar, Uttar Pradesh
- **Government Medical College, Anantapuramu**
Anantapuramu, Andhra Pradesh

- **Government Medical College, Anantnag**
Anantnag, Jammu and Kashmir
- **Government Medical College and Hospital**
Sector 32, Chandigarh
- **Government Medical College, Bettiah**
Bettiah, West Champaran, Bihar
- **Government Medical College, Bhavnagar**
Bhavnagar, Gujarat
- **Government Medical College, Dharashiv**
Dharashiv, Maharashtra
- **Government Medical College, Dindigul**
Dindigul, Tamil Nadu
- **Government Medical College, Handwara**
Handwara, Kupwara, Jammu and Kashmir
- **Government Medical College, Haridwar**
Haridwar, Uttarakhand
- **Government Medical College, Mahabubnagar**
Mahabubnagar, Telangana
- **Government Medical College, Miraj**
Miraj, Sangli, Maharashtra
- **Government Medical College, Nagaur**
Nagaur, Rajasthan
- **Government Medical College, Vikarabad**
Vikarabad, Telangana
- **Government Medical College, Virudhunagar**
Virudhunagar, Tamil Nadu
- **Graphic Era Institute of Medical Sciences**
Dehradun, Uttarakhand
- **GS Medical College**
Pilkhuwa, Hapur, Uttar Pradesh
- **GSL Medical College**
Rajamahendravaram, Andhra Pradesh
- **Gujarat Medical Education and Research Society Medical College, Morbi**
Morbi, Gujarat
- **Gujarat Medical Education and Research Society Medical College, Porbandar**
Porbandar, Gujarat
- **Gujarat Medical Education and Research Society Medical College, Vadnagar**
Vadnagar, Mehsana, Gujarat
- **Hamdard Institute of Medical Sciences and Research**
New Delhi, Delhi
- **Heritage Institute of Medical Sciences**
Varanasi, Uttar Pradesh
- **Indian Institute of Medical Science & Research**
Warudi, Badnapur, Jalna, Maharashtra
- **Indira Medical College and Hospitals**
Tiruvallur, Tamil Nadu
- **Institute of Medical Sciences and SUM Hospital, Siksha 'O' Anusandhan**
Bhubaneswar, Odisha
- **Institute of Medical Sciences and SUM Hospital, Campus II, Siksha 'O' Anusandhan**
Phulnakhara, Bhubaneswar, Odisha
- **Institute of Post Graduate Medical Education & Research**
Kolkata, West Bengal
- **Jagannath Gupta Institute of Medical Sciences and Hospital**
Budge Budge, South 24 Parganas, West Bengal
- **Jannayak Birsa Munda Government Medical College**
Nandurbar, Maharashtra
- **Jawaharlal Institute of Postgraduate Medical Education and Research**
Puducherry, Puducherry
- **Jawaharlal Nehru Institute of Medical Sciences**
Imphal, Manipur
- **Jawaharlal Nehru Medical College, Aligarh Muslim University**
Aligarh, Uttar Pradesh
- **Jawaharlal Nehru Medical College, Datta Meghe Institute of Higher Education & Research**
Wardha, Maharashtra
- **Jawaharlal Nehru Medical College, KLE Academy of Higher Education and Research**
Belagavi, Karnataka
- **Jorhat Medical College & Hospital**
Jorhat, Assam
- **JSS Medical College, JSS Academy of Higher Education & Research**
Mysuru, Karnataka
- **Jubilee Mission Medical College & Research Institute**
Thrissur, Kerala
- **K. J. Somaiya Medical College & Research Centre**
Mumbai, Maharashtra
- **Kakatiya Medical College**
Warangal, Telangana
- **Kalpna Chawla Government Medical College**
Karnal, Haryana
- **Kashmir Medical College and Hospital**
Sempora, Srinagar, Jammu and Kashmir
- **Kasturba Medical College**
Mangaluru, Karnataka
- **Kasturba Medical College**
Manipal, Udupi, Karnataka
- **Kempegowda Institute of Medical Sciences**
Bengaluru, Karnataka
- **KMCT Medical College**
Manassery, Mukkam, Kozhikode, Kerala
- **Late Shri Lakhiram Agrawal Memorial Government Medical College**
Raigarh, Chhattisgarh
- **Lord Buddha Koshi Medical College and Hospital**
Saharsa, Bihar
- **Mahabodhi Medical College & Hospital**
Gaya, Bihar
- **Maharaja Agrasen Kedar Nath Gupta Medical College**
Bahadurgarh, Jhajjar, Haryana
- **Maharaja Krushna Chandra Gajapati Medical College & Hospital**
Berhampur, Odisha
- **Maharashtra Institute of Medical Education and Research (MIMER) Medical College & Dr. B. S. T. R. Hospital**
Talegaon Dabhade, Pune, Maharashtra
- **Mahatma Gandhi Institute of Medical Sciences**
Sevagram, Wardha, Maharashtra
- **Mahatma Gandhi Medical College and Research Institute, Sri Balaji Vidyapeeth**
Pillaiyarkuppam, Puducherry

- **Malabar Medical College Hospital & Research Centre**
Modakkallur, Kozhikode, Kerala
- **Manipal Tata Medical College**
Jamshedpur, Jharkhand
- **MGM Medical College**
Nerul, Navi Mumbai, Maharashtra
- **MGM Medical College**
Vashi, Navi Mumbai, Maharashtra
- **Murshidabad Medical College & Hospital**
Berhampore, Murshidabad, West Bengal
- **MVJ Medical College and Research Hospital**
Hoskote, Bengaluru Rural, Karnataka
- **Mysore Medical College and Research Institute**
Mysuru, Karnataka
- **Nagaland Institute of Medical Sciences & Research**
Kohima, Nagaland
- **Narayana Medical College**
Nellore, Andhra Pradesh
- **Navodaya Medical College**
Raichur, Karnataka
- **Neelima Institute of Medical Sciences, Anurag University**
Ghatkesar, Telangana
- **Nil Ratan Sircar Medical College & Hospital**
Kolkata, West Bengal
- **Nimra Institute of Medical Sciences**
Jupudi, Ibrahimpatnam, NTR District, Andhra Pradesh
- **North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences**
Shillong, Meghalaya
- **NRI Institute of Medical Sciences**
Sangivalasa, Bheemunipatnam, Visakhapatnam, Andhra Pradesh
- **Pabitra Mohan Pradhan Medical College and Hospital**
Talcher, Angul, Odisha
- **Palakkad Institute of Medical Sciences**
Walayar, Palakkad, Kerala
- **Panimalar Medical College Hospital & Research Institute**
Varadharajapuram, Poonamallee, Chennai, Tamil Nadu
- **Pramukhswami Medical College**
Karamsad, Anand, Gujarat
- **PSG Institute of Medical Sciences and Research**
Coimbatore, Tamil Nadu
- **Punjab Institute of Medical Sciences**
Jalandhar, Punjab
- **R. K. Damani Medical College, ShriRamchandra Institute of Medical Sciences**
Chhatrapati Sambhajnagar, Maharashtra
- **Rabindranath Tagore Medical College**
Udaipur, Rajasthan
- **Radha Devi Jageshwari Memorial Medical College and Hospital**
Muzaffarpur, Bihar
- **Raniganj Institute of Medical Science**
Raniganj, Paschim Bardhaman, West Bengal
- **S. S. Institute of Medical Sciences and Research Centre**
Davangere, Karnataka
- **Saraswathi Institute of Medical Sciences**
Hapur, Uttar Pradesh
- **Seth G. S. Medical College and King Edward Memorial Hospital**
Mumbai, Maharashtra
- **Shantabaa Medical College & General Hospital**
Amreli, Gujarat
- **Shri B. M. Patil Medical College, Hospital and Research Centre**
Vijayapura, Karnataka
- **Shridevi Institute of Medical Sciences and Research Hospital**
Tumakuru, Karnataka
- **Shri Jagannath Medical College and Hospital**
Puri, Odisha
- **Shri M. P. Shah Government Medical College**
Jamnagar, Gujarat
- **Shri Sathya Sai Medical College and Research Institute, Sri Balaji Vidyapeeth**
Ammappettai, Chengalpattu, Tamil Nadu
- **Siddaganga Medical College and Research Institute**
Tumakuru, Karnataka
- **Sikkim Manipal Institute of Medical Sciences**
Gangtok, Sikkim
- **SMBT Institute of Medical Sciences & Research Centre**
Dhamangaon, Igatpuri, Nashik, Maharashtra
- **Smt. Kashibai Navale Medical College and General Hospital**
Narhe, Pune, Maharashtra
- **Soban Singh Jeena Government Institute of Medical Sciences and Research**
Almora, Uttarakhand
- **Sree Narayana Institute of Medical Sciences**
Chalacka, Ernakulam, Kerala
- **Sri Siddhartha Medical College**
Tumakuru, Karnataka
- **Srinivasan Medical College and Hospital**
Samayapuram, Tiruchirappalli, Tamil Nadu
- **SRM Medical College Hospital and Research Centre**
Kattankulathur, Chengalpattu, Tamil Nadu
- **Swaminarayan Institute of Medical Sciences and Research**
Kalol, Gandhinagar, Gujarat
- **Symbiosis Medical College for Women**
Pune, Maharashtra
- **Tagore Medical College and Hospital**
Rathinamangalam, Chennai, Tamil Nadu
- **Takshashila Medical College & Hospital**
Ongur, Tindivanam Taluk, Villupuram District, Tamil Nadu
- **Trichy SRM Medical College Hospital & Research Centre**
Irungalur, Tiruchirappalli, Tamil Nadu
- **University College of Medical Sciences and Guru Teg Bahadur Hospital**
New Delhi, Delhi
- **Vardhman Mahavir Medical College and Safdarjung Hospital**
New Delhi, Delhi
- **Vedantaa Institute of Medical Sciences**
Dahanu, Palghar, Maharashtra
- **Veer Surendra Sai Institute of Medical Sciences and Research**
Burla, Sambalpur, Odisha
- **Vyas Medical College & Hospital**
Jodhpur, Rajasthan
- **Yenepoya Medical College**
Mangaluru, Karnataka
- **Zoram Medical College & Hospital**
Falkawn, Aizawl, Mizoram

CHAPTER 9

Continuing Resources and Acknowledgments

A Living Academic Resource

This Blueprint documents the first phase of the SIG's work. The consultation findings, expert deliberations and proposed workstreams are intended to provide a starting point for continuing academic development rather than a fixed implementation standard.

Detailed resources will evolve as expert groups and participating institutions develop and test cases, assessment approaches, faculty-development resources, implementation guidance, multilingual approaches and research methods.

Supporting implementation resources, detailed tools, and future updates to this Blueprint will be made available through the SIG Clinical Communication resource repository at sigclinicalcomms.com.

Acknowledgments

The Special Interest Group on Clinical Communication acknowledges the Deans, Principals, Medical Education Units, AETCOM leads and faculty members who contributed institutional responses to the national consultation. The SIG also acknowledges the educators, clinicians and institutional contributors participating in the national advisory process and the organizations supporting the continuing academic work.

The consultation and this Blueprint are intended to reflect a collective implementation question rather than the position of any single institution. Participation in the consultation or advisory process does not imply endorsement of a particular technology platform, assessment model or future institutional program.

Special Interest Group on Clinical Communication
www.sigclinicalcomms.com
info@sigclinicalcomms.com



Continuing resources. Scan to reach the SIG website, updates, and the participating-institution network.
www.sigclinicalcomms.com

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NOTES

Notes

NOTES



SIG
CLINICAL
COMMUNICATION

Advancing Medical Education and Training
in Clinical Communication

From Intent to Implementation

National Consultation and Implementation Blueprint, 2026

*A more human, more equitable, more effective
healthcare system through better communication.*



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