Constructing communication skills through preparation, experience, reflection and feedback

Susan J. Hawken,[1] Marcus A. Henning[2]

[1]Department of Psychological Medicine, Faculty of Medical and Health Sciences and [2]Centre for Medical and Health Sciences Education, University of Auckland, New Zealand

Abstract

The skill of communication is one of the foundation stones of medical practice and profoundly influences patient-care and health outcomes. The importance of teaching, assessing, and learning communication skills in undergraduate medical education is supported by the literature, as is continually addressing these skills in continuing medical education practice. The following article explores the innovative nature of a communication skills examination and feedback from medical students early in their clinical training in relation to a communication skills examination process. This process comprises a learning cycle of preparation, experience, self-appraisal, and examiner feedback. A total of 125 students provided feedback on this examination process by responding to four items related to this communication skills examination. The evaluation statistics showed that students responded favourably to the usefulness of the examination showing that all four domains are integral to the examination process. This communication skills examination process with its learning activities is effective on several levels as it provides a summative grade that can be used as a measure for competency and it creates a significant impact on learning.

Introduction

The skill of communication is crucial to establishing quality medical practice and patient-centred health care.[1,2] The teaching and assessment of these skills is vital when introducing medical students to the learning communication skills,[3-6] and the importance of refining and developing communications skills is likely to be a continuing medical education practice.[7,8] The area is the innovation presented in this paper addresses the development of a comprehensive, context specific and effective communication skills examination. The Medical Programme at the School of Medicine, University of Auckland has been committed to teaching communication skills for over 20 years and this present examination process was a reinvigoration of the communication skills examination developed by Grant.[9-11]

One of the problems with the measure of communication skills acquisition is psychometric robustness.[12] Wass and colleagues proposed that the skills and attitudes towards communication skills could be assessed using the objective structured clinical examination (OSCE) format. However, the OSCE has problems associated with case-specificity and generalisability across clinical settings, and there is evidence to suggest that the OSCE is not favoured by students.[13] One of the *catch cries* of medical education is that *assessment drives learning.*[12] Hence, it is imperative that medical educators consider the effectiveness of assessments not only in terms of evaluation but also with respect to context, information transfer and impact on learning.

Correspondence: Susan J. Hawken, Department of Psychological Medicine, Faculty of Medical and Health Sciences, University of Auckland, Private Bag 92-019, Auckland 1142, New Zealand.
Tel. +64.9.923.2588 - Fax: +64.9.373.7013.
E-mail: s.hawken@auckland.ac.nz

Key words: communication skills, physician-patient relationship, reflection.

Conflict of interests: the authors report no potential conflict of interests.

Received for publication: 10 August 2011.
Revision received: 9 May 2012.
Accepted for publication: 10 May 2012.

Medical Education Development 2012; 2:e6
doi:10.4081/med.2012.e6

Innovation

The competency measures used to assess these communication skills were adapted from the Calgary-Cambridge guide to consultation.[14] This assessment was developed to attend to the unique and diverse cultural environment of healthcare that students are likely to be exposed to. In New Zealand, the 2006 census statistics suggest 77% of the population were classified as European, 15% Mori, 10% Asian, 7% Pacific Islands peoples and 1% Middle Eastern, Latin American, and African implying a diverse patient pool.[15] This innovative exam process was developed to assess students' competencies when working with patients in accordance with the New Zealand healthcare context. This revised communication skills examination was designed to be patient-centred by evaluating a student's understanding of the patient's problem, through clarifying medical detail and attending to relevant background factors.

The competency measures have several assessment phases that include: initiating the session, gathering information, providing structure, building relationship, explanation and planning, and closing the session.[14] To develop a contextually specific patient-centred focus, the first author decided to refine this system to entail a preparation session of two hours in which patient-centred interviewing skills were revised and experiential role plays are conducted in small groups. Subsequent to this, the examination process involved interviewing a simulated patient (a highly trained professional actor) which was videotaped. The video recording was given immediately to the student who then reviewed their performance and completed an appraisal of their skills using an assessment grid which included reporting what they had done well and what they needed to work on. The examiners then reviewed the interview and the student appraisal with the marking emphasis being on the student's insight into their performance. The examiners offered written feedback which was then given back to the students.

When making decisions about the accuracy of an assessment three aspects need to be taken into account.[16] The first to consider is the evaluation of the performance under scrutiny so that conclusions about whether the performance is competent or not can be made. Second is to consider whether the assessment can be used in other settings or with other groups or its generalisability. And finally, it is useful to ascertain whether the assessment can predict future performance or extrapolation.

We were also very cognisant of the patient-centred approach, and drew from the work of Dalen and colleagues,[17] who suggested that communication skills encompass the areas of the doctor-patient relationship, the transfer of relevant verbal information, and the methods used to negotiate a solution to the presenting problem. Consequently, our assessment was based around these skills. A further point of consideration is the focus of context-specific patient care. The notion of doctor-centredness versus patient-centredness has been well researched and some evidence suggests that students can be influenced by medical environments that promote a more doctor-centred approach to communication.[18] In this commu-

nications skills examination the first author ensured that the actors represented a cross-section of New Zealand society, and in this way this could become familiar with the notion *therapeutic alliance,*[19] therefore the examination process had explicit and implicit links back to students' learning.

Evaluation

We evaluated student feedback about this examination process by surveying 125 students (a response rate of 76%) on their experiences associated with the assessment. Students were invited to respond to four items related to the preparation session, examination experience, reflection on the consultation and written appraisal, and examiner feedback. The actual wording of the items was as follows: i) how useful were the preparation sessions for you?; ii) how useful was the examination experience for you?; iii) how useful was it reflecting on your consultation and writing your own appraisal? and iv) how useful was the examiner's feedback to you? Items were scored in terms of how useful students felt the examination was [Not at all useful (1) to extremely useful (7)]. Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee.

The reliability of the four items on the examination was established (Cronbach alpha =0.76). The results (Table 1) showed that students viewed this communication skills examination as worthwhile on all four domains with *feedback* being perceived as the *least* worthwhile. The findings of this study are consistent with similar evaluative studies.[13]

In this evaluation, students accentuated the value of the communication skills examination after the examination itself, indicating that the learning is in the evaluation of the *performance - assessment drives learning.*[12] This is consistent with the notion of Miller's pyramid of clinical competence and the conceptual and clinical difference between knowing, knowing how, showing and doing.[12,20,21] The findings may indicate that students feel that they know how to do the communications skills tasks before the examination but it is only after the engaging in a *real* test of the task that they begin to show that they can do it. This indicates that the communication skills examination was a good indicator in terms of measuring performance and may be a predictor of extrapolation.

In addition, the reflective aspect of the consultation and writing their own appraisal was highlighted by students in terms of making an impact on their learning. This finding could be linked to Miller's notion of *doing* built on *knowing how*. Students' reflections and their examination experience likely heighten their levels of awareness about the importance of developing communication skills and relating this to the clinical environment. The reflection component may add to the notion of clinical competence,[21] and the actual examination process probably emphasizes the reflective process thus building a cycle of proficiency similar to the learning model espoused by Schon.[22]

Table 1. Medians, means, standard deviations and skewness (and standard error) of evaluation measures for each of the competency items.

Evaluation measures	*N*	Median	Mean	*SD*	Skewness	*SE* of skewness
Preparation	125	5.00	4.70	1.39	-0.59	0.22
Examination	125	5.00	4.34	1.59	-0.35	0.22
Reflection	125	5.00	4.87	1.51	-0.68	0.22
Feedback	108*	4.00	4.43	1.58	-0.53	0.22

*17 students had not yet received *feedback* on their examination. SD, standard deviation; SE, standard error.

Conclusions

This process of examination is innovative because it provides context specific role plays and is philosophically akin to patient- centredness. The student evaluation of this examination showed that students tended to show that the communication skills examination was worthwhile across all key domains. Consequently, the examination experience had a positive influence on students and likely had an impact on the promotion of reflective learning. Further evaluations will require more focus on the examination itself by considering aspects of inter-rater reliability and criterion-related validity.

References

1. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. J Fam Pract 2000;49:796-804.
2. Stewart MA. Effective physician-patient communication and health outcomes: a review. CMAJ 1995;152:1423-33.
3. Lee KB, Vaishnavi SN, Lau SKM, et al. Cultural competency in medical education: demographic differences associated with medical student communication styles and clinical clerkship feedback. J Natl Med Assoc 2009;101:116-26.
4. Von Fragstein M, Silverman J, Cushing A, et al. UK consensus statement on the content of communication curricula in undergraduate medical education. Med Educ 2008;42:1100-7.
5. Brown J. How clinical communication has become a core part of medical education in the UK. Med Educ 2008;42:271-8.
6. Jones R, Higgs R, De Angelis C, Prideaux D. Changing face of medical curricula. Lancet 2001;357:699-703.
7. Berkhof M, van Rijssen HJ, Schellart AJM, et al. Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. Patient Educ Couns 2011;84:152-62.
8. Silverman J. Clinical communication training in continuing medical education: possible, do-able and done? Patient Educ Couns 2011;84:141-2.
9. Grant VJ. Doctor-patient communication: a five year training programme for medical students. N Z Med J 1988;101:424-6.
10. Grant VJ, Hawken SJ. What do they think of it now? Medical graduates' views of earlier training in communication skills. Med Teach 2000;22:260-4.
11. Grant VJ. Teaching analysis. Health Care Anal 1995;3:71-4.
12. Wass V, Van der Vleuten C, Shatzer J, Jones R. Assessment of clinical competence. Lancet 2001;357:945-9.
13. Rees C, Sheard C, McPherson A. Communication skills assessment: the perceptions of medical students at the University of Nottingham. Med Educ 2002; 36:868-78.
14. Silverman J, Kurtz S, Draper J. Skills for communicating with patients. 2nd ed. Oxford: Radlciffe Publishing; 2005.
15. Ministry of Social Development. Ethnic composition of the population 2010. Available from: http://www.socialreport.msd.govt.nz/people/ethnic-composition-population.html. Accessed on: January 2011.
16. Kane MT. The assessment of professional competence. Eval Health Prof 1992;15:163-

82.
17. Dalen J, Zuidweg J, Collet J. The curriculum of communication skills teaching at Maastricht Medical School. Med Educ 1989;23:55-61.
18. Egnew TR, Wilson HJ. Faculty and medical students' perceptions of teaching and learning about the doctor-patient relationship. Patient Educ Couns 2010;79:199-206.
19. Bertakis KD, Franks P, Epstein RM. Patient-centered communication in primary care: physician and patient gender and gender concordance. J Womens Health 2009;18:539-45.
20. Norcini JJ. Work based assessment. BMJ 2003;326:753-5.
21. Miller GE. The assessment of clinical skills/competence/performance. Acad Med 1990;65:S63-7.
22. Schön DA. Educating the reflective practitioner: toward a new design for teaching and learning in the professions. San Francisco, CA: Jossey-Bass; 1987.