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Creation of an active learning healthcare communications course using simulations relevant to pharmacy practice

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ABSTRACT

Background and purpose: The purpose of this project was to design and develop a health care communications course built around practice-like simulations and active learning in the first year of a professional pharmacy program.

Educational activity and setting: A three-credit health care communications course was divided into one didactic (two hours per week) and three simulation components (one hour per week). The simulation components consisted of one written patient education pamphlet, three group presentations, and three one-on-one patient counseling sessions. This was accomplished by breaking the class of approximately 75 students into eight separate sections, each consisting of 8–10 students and one instructor. Each week four sections were devoted to counseling role-plays: half in the role of pharmacists and half as patients. The other four sections were devoted to hour-long professional group presentations—half in the presenting group and half as audience. The students' performance in the simulated counseling sessions and group presentations has been tracked and analyzed to determine if the simulated exercises had a positive impact on the students' active communications skills.

Findings: Consistently, over the first four years of the implementation of the course, students' communications skills, as measured by faculty assessments, in both professional group presentations and one-on-one counseling sessions significantly improved.

Discussion and summary: Incorporation of active-learning simulation exercises into a healthcare communications course has a positive impact on the development of students' communications skills. This creates a foundation upon which students can build over the remainder of the professional program and into their future careers.

Background and purpose

Communications for healthcare majors

The relationship between the provision of healthcare and provider-patient communications has long been of vital importance to the medical professions. Particularly in the last four decades, this has been a focus of attention for health care majors; however, reference to the importance of such communications can be traced back to Hippocrates around 460 Before the Common Era (B.C.E.).[1]

During the 19th Century, health care communications was identified as a powerful and intricate process, split into several categories: intrapersonal, interpersonal, group, organizational, and societal.[2] The importance of incorporating health care communications into medicine was solidified with the creation of the Health Communication Division of the International

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Communication Association, which formed the Commission for Health Communication within the Speech Communication Association in 1985.[2] In the 1980s, communications scholars began publishing books on health care communications, ultimately creating a platform for the initial research in this field of study. At the same time, medical schools and colleges began offering courses in health care communications, at both graduate and undergraduate levels.

Part of the academic interest in the field of communications emerged from federal initiatives regarding public health—specifically, health care delivery and public health promotion. Despite the push from public health promotion activists, early health care communications courses were primitive in nature and typically disseminated from departments of speech communications, focusing primarily on interviewing skills. The research that followed the patient education and consumerism movements revolutionized how communication courses were delivered in medical schools and health care programs. Thus, health care communication stopped being viewed as "unnecessary bedside manners" within organized medicine, and instead, became a powerful tool in the provision of health care and the promotion of the public health.[2]

Today, the two most common communication models referenced in medical practice are the interpersonal model and the mass communication model. The interpersonal communication model focuses on face-to-face communication between two or more individuals. It has received wide acceptance in medicine due to its applicability to the patient–provider relationship. The mass communication model debuted in the late 1980s, proposing a different way of conveying medical information to large groups of patients via multi-channeled social systems (e.g., social media, healthcare marketing, and policy-making). The need for mass communication arose from the demographic changes that occurred in patient populations and the need for an effective means to promote public health campaigns.

History of health communication in the pharmacy profession

The counseling of patients regarding their medications was not always the focus or duty of U.S. pharmacists. Demonstrative of this during the past century was the following statement found in the 1952 American Pharmaceutical Association (APhA) Code of Ethics: "The pharmacist does not discuss the therapeutic effect or composition of a prescription with a patient. When such questions are asked, he suggests that the qualified practitioner is the proper person with whom such matters should be discussed."[3] A similar statement was also present in the 1922 APhA Code of Ethics.[4] The primary role of the pharmacist during this time period was to protect the public health, by "safeguarding the preparation, compounding, and dispensing of drugs and the storage and handling of drugs and medical supplies."[3] Clearly, pharmacist communication with the patient was not a concern of the profession or of the profession's academics.

This all began to change during the 1960s; although, the forces behind those changes undoubtedly started before that decade. The Pharmaceutical Survey, conducted from 1946 to 1949, initially recommended an expansion of the then current pharmacy curriculum from four years of study to six years of study culminating in the Doctor of Pharmacy degree.[5] The Pharmacist Code of Ethics, as revised in 1969, expanded pharmacists' responsibilities to include the counseling of patients, by rendering "to each patient the full measure of his ability" and making available his professional knowledge as may be required according to "his best professional judgment."[6] In 1960, pharmacist Eugene White restyled his pharmacy in Berryville, Virginia to an office practice model; and in 1965 the APhA promoted its Pharmaceutical Center community pharmacy business model, based on White's design.[7]

Over the next few decades, the clinical pharmacy movement began to draw national attention. In 1990, the U.S. Omnibus Budget Reconciliation Act (OBRA) was passed, requiring pharmacists to offer to counsel all Medicaid patients regarding their medicine.[8] This provision was established after research data emerged showing reductions in the cost of medicine, the number of prescriptions, the number of physician visits, and the number of healthcare complications with increased pharmacist-patient consultations.[9] In 2003, the American Pharmaceutical Association changed its name to American Pharmacists Association with a new mission and slogan for pharmacists: "Improving medication use and advancing patient care."[10] As the profession began to value and endorse pharmacist-patient communication, pharmacy academia began to notice.

During the 1990s, pharmacy academia, at both the international and the national levels, began to respond to the need for better communications skills.[11] For example, in 1997 both the World Health Organization and the International Pharmaceutical Federation issued reports delineating communications skills as essential to the practice of pharmacy.[11] The response of most pharmacy schools was to create a didactic-based communications course, reminiscent of the "Basic Speech Course[*s*]," but with one-on-one communications training added in. It was only in the last decade, that pharmacy communications courses began to incorporate role play and/or simulations training.[11,12] In addition, a literature search of such courses shows that the majority, if not all, are not presented until the second or third professional year, typically just prior to advanced pharmacy practice experiences (APPEs).[12–16] Unfortunately, by this point in a professional pharmacy curriculum, the student has missed numerous opportunities to utilize and further develop communication skills through regular courses, introductory pharmacy practice experiences (IPPEs), and pharmacy internships.

Educational activity and setting

Background

It is indisputable that the basic communications course serves as a fertile ground for pedagogical innovation in higher education. It is also evident that these courses often lack active, problem-based, and simulation learning activities—essential in the training of a healthcare professional. The primary goals of the design of our Healthcare Communications course was to: (1) add effective