

Medical Education

Long-term effect of communication training on the relationship between physicians' self-efficacy and performance

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ARTICLE INFO

Article history:

Received 31 July 2012

Received in revised form 13 November 2012

Accepted 20 November 2012

Keywords:

Communication skills training

Self-efficacy

Performance

Longitudinal study

ABSTRACT

Objective: To examine the long term impact of a communication skills intervention on physicians' communication self-efficacy and the relationship between reported self-efficacy and actual performance.

Methods: 62 hospital physicians were exposed to a 20-h communication skills course according to the Four Habits patient-centered approach in a crossover randomized trial. Encounters with real patients before and after the intervention (mean 154 days) were videotaped, for evaluation of performance using the Four Habits Coding Scheme. Participants completed a questionnaire about communication skills self-efficacy before the course, immediately after the course, and at 3 years follow-up. Change in self-efficacy and the correlations between performance and self-efficacy at baseline and follow-up were assessed.

Results: Communication skills self-efficacy was not correlated to performance at baseline ($r = -0.16$; $p = 0.22$). The association changed significantly ($p = 0.01$) and was positive at follow-up ($r = 0.336$, $p = 0.042$). The self-efficacy increased significantly (effect size $d = 0.27$). High performance after the course and low self-efficacy before the course were associated with larger increase in communication skills self-efficacy.

Conclusion: A communication skills course led to improved communication skills self-efficacy more than 3 years later, and introduced a positive association between communication skills self-efficacy and performance not present at baseline.

Practice implications: Communication skills training enhances physicians' insight in own performance.

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1. Introduction

Patient-centered communication is an integral aspect of medical care [1] and has been promoted for decades [2,3]. However, changing the standard of communication has been slow and difficult [4–8] and the long term impact of communication skills training on physician's assessment of their own communication skills is unknown.

Improving patient-centered care can be difficult because physicians receive very little feedback about their performance. In general, patient satisfaction is highly positively skewed [9,10], and physicians receive few criticisms of their communication behavior from their patients. This may lead to high confidence in

their communication skills [11]. Moreover, today's physicians are in general polite and friendly, masking deficiencies in patient-centered communication [12].

High communication self-efficacy means having confidence in ones' own communication skills. However, this confidence may or may not be appropriate when compared to actual communication performance. Two reviews have concluded that professionals' ability to assess their clinical skills is imprecise, and more so if their skills are poor [13,14]. This has also been shown for physicians' skills in general [15] and communication skills in particular [15,16]. Medical students' self-assessment accuracy is particularly low for communication skills [17–19]. Self-assessment is strongly linked to self-attributions [13], and hard to disentangle from self-efficacy [20] – probably even more so in the absence of feedback. Lack of insight into deficits in one's own performance could potentially explain lack of motivation for improvement, which is troublesome as self-directed learning has been considered a cornerstone of professional development in medicine for several years [21–23]. However, attending a course may be an eye-opener.

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Physicians whose self-efficacy was reduced after a communication skills course, developed a stronger belief in the effect of such a course on improvement of their skills [24].

Given that physicians receive very little feedback about their communication performance, we hypothesize that communication skills training will not only increase self-efficacy, but also accuracy of the self-efficacy when compared with objectively measured performance. The aims of this study were to explore whether the association between physician communication skills self-efficacy and actual performance changed following a communication skills course, and which variables could predict a change in self-efficacy from baseline to follow-up. To our knowledge, this is the first study to explore long term consequences to self-efficacy and accuracy of that self-assessment after a long follow-up period.

2. Methods

2.1. Design

This is an observational study following a crossover randomized controlled trial in 2007–2008 [25] with follow-up data collected in 2011. Participating physicians were assessed on videotapes before and up to 12 months (mean 154 days, standard deviation 87 days) after a communication skills course. Data on self-efficacy was collected when the course started, on leaving the course and by a mail survey at follow-up in 2011. Eight encounters were videotaped per physician, of these two before the first course (constituting the baseline assessment). Due to the crossover design, half of the physicians have two observed encounters before the intervention and six after, and the other half vice versa (Fig. 1). Because of this, performance scores for physicians after the intervention were based on averages of 2 or 6 videotapes. The course used the Four Habits approach developed in Kaiser Permanente, California, and piloted in Norway [26,27]. The objective was to teach the physicians about important patient-centered communication skills, and inspire them to train systematically after the course. Over two 10-h days participants were exposed to a half-and-half mix of role-plays in small groups and plenaries with theory and debriefing. In the role-plays, physicians played patients as well as themselves. Physicians were given feedback during role-plays within the course, but no feedback on their behavior in the videotaped encounters.

2.2. Participants

Eligible participants included all physicians less than 60 years of age working in the non-psychiatric clinical departments of a teaching hospital in the capital area of Norway. Physicians were selected for invitation to participate by a random drawing stratified on department and position (fully licensed specialists (seniors)/specialists in training (juniors)). Seventy-one of 103

Table 1

The skills included in the measure of self-efficacy. The question was: “How certain are you that you can successfully perform the following tasks?”.

Initiate a conversation with a patient regarding his/her worries
Conclude a consultation with a summary of the problems and a treatment plan
Assess symptoms of anxiety and depression
Communicate bad news to a patient
Confront in an appropriate manner a patient who denies his/her illness
Cope with a situation in which a patient or a relative expresses disagreement with you as a doctor
Encourage a patient to describe his/her feelings
Initiate a conversation with a patient regarding his/her worries
Conclude a consultation with a summary of the problems and a treatment plan

invited physicians (69%) agreed to participate, eventually 62 (60%) received the intervention. Participating physicians did not significantly differ from the original physician population in terms of gender, age, proportion of senior or junior physicians, or specialty [24]. A sufficient number of videotapes were collected for 56 of the 62 physicians after having received the intervention. Reasons for attrition were mainly maternity leaves (female physicians) or too few available patients (mainly in anaesthesiology) [25].

2.3. Measurements

Communication self-efficacy was measured by the question: “How certain are you that you can successfully perform the following tasks?” in which responses should be given on a scale from 1 (very uncertain) to 10 (very certain) with regard to the nine tasks listed in Table 1. Self-efficacy score was the sum of responses across tasks. This measure was developed and validated in the United Kingdom [28] and translated for use in Norway [24]. It has been used in other clinical studies [29,30]. The follow-up survey also contained the question: “Did the course make lasting impact on your clinical practice?” with the answering options “yes”, “no”, and “uncertain”.

The physicians' communication skills performance was evaluated using the Four Habits Coding Scheme (4HCS), developed by Krupat et al. to systematically evaluate the quality of physician patient-centered communication [31]. The 4HCS was modeled after the Kaiser Permanente approach used in the communication skills training, and showed acceptable reliability and validity (compared with Roter Interaction Analysis System coding) in the original study [31]. The coding scheme consists of 23 items organized into Four Habits: investing in the beginning, eliciting of the patient's perspective, demonstrating empathy and investing in the end of the visit. The items are scored on a 5-point scale from 1 = not very effective to 5 = highly effective and the physician's score is a sum across the 23 items. Four experienced psychology

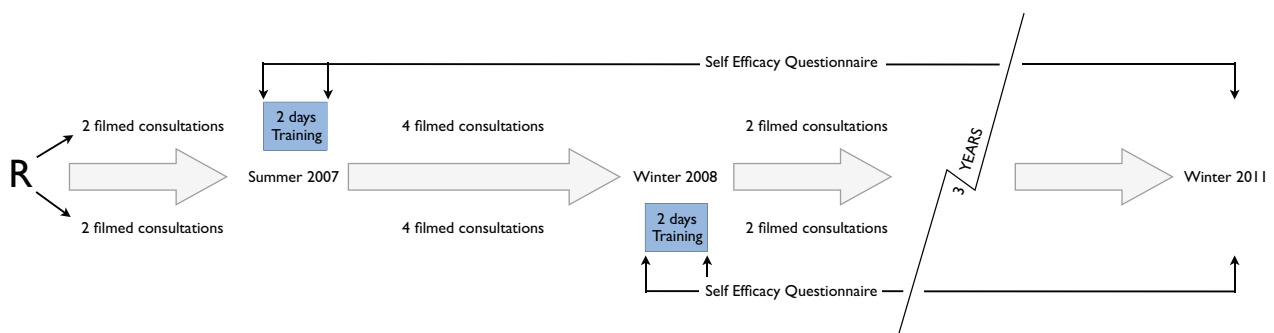


Fig. 1. Study design. R marks randomization to two groups.

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