



Communication Skills Training

The effects of self-assessment and supervisor feedback on residents' patient-education competency using videoed outpatient consultations



Jan C. Wouda*, Harry B.M. van de Wiel

University of Groningen, University Medical Center Groningen, The Netherlands

ARTICLE INFO

Article history:

Received 20 November 2013
 Received in revised form 26 May 2014
 Accepted 27 May 2014

Keywords:

Workplace-based assessment
 Clinical communication
 Residents
 Supervisors
 Feedback on videoed consultations

ABSTRACT

Objectives: To determine the effects of residents' communication self-assessment and supervisor feedback on residents' communication-competency awareness, on their patient-education competency, and on their patients' opinion.

Methods: The program consisted of the implementation of a communication self-assessment and feedback process using videoed outpatient consultations (video-CAF). Residents wrote down communication learning objectives during the instruction and after each video-CAF session. Residents' patient-education competency was assessed by trained raters, using the CELI instrument. Participating patients completed a questionnaire about the contact with their physician.

Results: Forty-four residents and 21 supervisors participated in 87 video-CAF sessions. After their first video-CAF session, residents wrote down more learning objectives addressing their control and rapport skills and their listening skills. Video-CAF participation improved residents' patient-education competency, but only in their control and rapport skills. Video-CAF participation had no effect on patients' opinion.

Conclusions: Video-CAF appears to be a feasible procedure and might be effective in improving residents' patient-education competency in clinical practice.

Practice implications: Video-CAF could fill the existing deficiency of communication training in residency programs.

© 2014 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Since the introduction of competency frameworks in medical education, workplace-based assessment has come into focus for accountability and certification purposes, as well as for the steering and support of learning in clinical practice [1–6]. Valid workplace-based assessment requires reliable direct observations. To be effective as a learning tool, the assessment should also be followed by feedback fulfilling certain requirements [7–14].

The introduction of competency frameworks in medical-specialist training also encouraged the attention to communication in clinical teaching [15]. Nowadays, direct observation followed by effective feedback is considered to be a powerful means to teach communication skills in clinical practice [16–20].

Communication assessment and feedback have already featured in the training of general practitioners and primary care physicians for several decades as part of vocational training and certification. Workplace-based assessment of medical-specialist trainees' communication occurs less frequently [21,22]. Furthermore, research into the effects of workplace-based assessment on clinical performance remains underdeveloped [2,23].

Videoing real consultations for communication assessment and feedback purposes is nowadays a widely accepted and applied method in undergraduate medical education [24] and in general practitioners' vocational training [20,25–32]. Video review of patient encounters appears to improve students' self-assessment and communication performance [24]. Moderate effects on general practitioners' communication performance in daily practice were reported in a randomized controlled study investigating workplace-based assessment and feedback using videoed consultations [29]. Videoing residents' consultations for communication assessment and feedback remains uncommon and subject to debate [33–35]. This is regrettable, since video review has several advantages over direct observation by clinical supervisors [24,36–39]. One

* Corresponding author at: Wenckebach Institute, FC33, University Medical Center, PO Box 30001, 9700 RB Groningen, The Netherlands. Tel.: +31 503612045; fax: +31 503619326.

E-mail address: j.c.wouda@umcg.nl (J.C. Wouda).

major advantage is the possibility of reflection based on self-observation. If reflection is guided by communication-behavior benchmarks, video review significantly improves self-assessment quality and communication self-awareness [12,24,40], which are prerequisites of communication behavior improvement [41,42].

The role of clinical supervisors is arguably crucial to attain valid assessments and to provide effective feedback. However, several studies have pointed to the supervisors' lack of sufficient insight into communication skills [43,44], the unreliability of supervisors' assessments of residents' communication [6,45], and the inadequacy of supervisors' feedback to residents [21,44,46–49]. Supervisors should therefore be trained in communication-competency assessment and in the skills required to provide residents with effective feedback [1,4,9,22,24,49–53].

We investigated the effects of an innovative program for communication self-assessment supplemented with supervisor feedback, on residents' communication-competency awareness and on their communication competency in general and their patient-education competency in particular. By patient-education competency, we refer to the proficient use of communication skills in order to influence the patients' knowledge, opinions, and health and illness behavior so as to ensure that the patient is able to cooperate effectively in deciding on the care that he/she receives, and can make the best possible contribution to that care [54]. The program focused on patient-education competency, since patient education takes place in almost all medical consultations, requires excellent performance of communication skills, and is therefore an essential component of the physician's role as a communicator [55]. The program consisted of the implementation of a procedure for communication self-assessment and supervisor feedback using videoed outpatient consultations, supplemented with the training of supervisors and the instruction of residents. Residents' participation in the program was expected to:

- (1) enhance their awareness of their strong and weak points in communication (learning objectives);
- (2) improve their patient-education competency in outpatient consultations;
- (3) yield more positive opinions on the part of their patients about their contact with the resident.

We also investigated whether resident characteristics, such as years in residency, gender, and background in communication-skills training, were related to residents' awareness of their communication competency, their patient-education competency, and their patients' opinion about the contact.

2. Methods

2.1. Video-CAF

The procedure for Communication Assessment and Feedback using videoed consultations, called video-CAF, consists of the video and audio recording of all consultations at a resident's outpatient clinic, conditional on patient consent. Physical examinations and medical procedures are audio recorded but not video recorded. Participating patients complete a questionnaire after the consultation to evaluate their contact with the resident. Their responses are fed back anonymously to the resident (see Section 2.5). After completing the clinic, the resident selects two consultations for self-assessment and supervisor feedback. The selection is guided by the consultation's complexity or communication obstacles, as well as by the resident's communication learning objectives (see Section 2.4). Both resident and supervisor assess the communication quality in the selected consultations with the CELI instrument (see Section 2.2). Subsequently, they discuss the two selected

consultations guided by the resident's learning objectives and the CELI assessments. The medical content of both consultations is also discussed. The feedback discussion, which usually lasts 60–90 min, follows a preset agenda to guarantee the prerequisites of effective feedback. After the feedback discussion, the resident writes down a new list of learning objectives and documents the form in her or his portfolio. The new learning objectives are used as guidelines in the following video-CAF session, which is held between six and twelve months later.

The video-CAF process was implemented in 2009 in two departments of the University Medical Center Groningen, The Netherlands. A coordinator schedules the recording sessions and feedback discussions, arranges for consent from patients, collects the completed questionnaires, and manages the equipment and recordings. Consultation recordings are destroyed after the feedback discussion, unless patients consented to their use for research purposes.

We labeled each consultation used for self-assessment and feedback, with the resident's identification code, the *consultation number* indicating the successive number of each consultation, and the *video-CAF number* indicating whether the consultation was performed at the resident's first, second or third participation in the video-CAF process (values 0, 1 or 2).

2.2. CELI assessment

All consultations selected by the residents for self-assessment and feedback, were assessed by a trained rater using the CELI instrument [56]. Approximately half of these consultations were also independently assessed by a second trained rater for reliability analysis.

The CELI instrument assesses a physician's patient-education competency by assigning scores to the performance of separate communication skills. A communication skill is defined as a discrete and observable instance of verbal and/or non-verbal behavior (an utterance) by which the physician contributes to the efficient attainment of the conversational objectives [57]. The CELI instrument is based on a patient-education model that distinguishes four tasks that a physician should perform in order to reach the consultation's patient-education goals. The four tasks are denoted as patient-education subcompetencies and consist of: (1) Control of the conversational flow and building rapport, (2) Explaining, (3) Listening, and (4) Influencing. The communication skills required for attaining patient-education objectives are grouped into the four subcompetencies. Appendix A contains an overview of the four subcompetencies and their matching skills.

The performance of a skill is assessed on a four-point scale: –2 = poor, –1 = inadequate, +1 = adequate, +2 = good. If the physician does not perform a skill where the performance is advisable, the skill is scored –1 (=advisable) or –2 (=strongly advisable). The skills are evaluated for their intrinsic quality – how well the skill was performed – and for their contextual quality – the moment in the consultation at which the skill was performed [58]. Each of the physician's utterances receives a single score for the performance of the skill which the utterance represents. The score consists of the letter, denoting the subcompetency to which the skill belongs, and a performance score. For example, if a physician adequately reflects the feelings of the patient, this utterance is scored L+1, meaning that a listening skill was performed adequately. The time at which a specific skill was observed, and a short comment about the performance of that skill is also noted on the CELI scoring form. Depending on the goals and the consultation process, some skills are evaluated frequently, some skills only infrequently, and some skills are not relevant. The rules for these ratings are set out in an illustrated manual.

Download English Version:

<https://daneshyari.com/en/article/6154006>

Download Persian Version:

<https://daneshyari.com/article/6154006>

[Daneshyari.com](https://daneshyari.com)