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The Group Objective Structured Clinical Experience: Building communication skills in the clinical reasoning context

Lyuba Konopasek [a,b,*], Kevin V. Kelly [c], Carma L. Bylund [d,e], Suzanne Wenderoth [f], Carol Storey-Johnson [g]

[a] NewYork-Presbyterian Hospital, Graduate Medical Education, New York, NY, USA
[b] Weill Cornell Medical College, Department of Pediatrics, New York, NY, USA
[c] Weill Cornell Medical College, Department of Psychiatry, New York, NY, USA
[d] Hamad Medical Corporation, Department of Medical Education, Doha, Qatar
[e] Weill Cornell Medical College-Qatar, Department of Psychiatry, Doha, Qatar
[f] Reading Health System, Department of Internal Medicine, Reading, PA, USA
[g] Weill Cornell Medical College,Weill Department of Medicine, New York, NY, USA

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ABSTRACT

Objective: Students are rarely taught communication skills in the context of clinical reasoning training. The purpose of this project was to combine the teaching of communication skills using SPs with clinical reasoning exercises in a Group Objective Structured Clinical Experience (GOSCE) to study feasibility of the approach, the effect on learners' self-efficacy and attitude toward learning communication skills, and the effect of providing multiple sources of immediate, collaborative feedback.
Methods: GOSCE sessions were piloted in Pediatrics and Medicine clerkships with students assessing their own performance and receiving formative feedback on communication skills from peers, standardized patients (SPs), and faculty. The sessions were evaluated using a retrospective pre/post-training questionnaire rating changes in self-efficacy and attitudes, and the value of the feedback.
Results: Results indicate a positive impact on attitudes toward learning communication skills and self-efficacy regarding communication in the clinical setting. Also, learners considered feedback by peers, SPs, and faculty valuable in each GOSCE.
Conclusion: The GOSCE is an efficient and learner-centered method to attend to multiple goals of teaching communication skills, clinical reasoning, self-assessment, and giving feedback in a formative setting.
Practice implications: The GOSCE is a low-resource, feasible strategy for experiential learning in communication skills and clinical reasoning.

1. Introduction

Numerous studies have demonstrated the importance of effective patient–physician communication and interpersonal skills in the medical encounter in the areas of diagnostic accuracy, patient adherence, physician and patient satisfaction, quality improvement and patient safety [1–8]. Intermediate outcomes such as self-efficacy, trust, and mutual understanding which can impact improved health outcomes have also been linked with communication skills [9]. Medical schools and residency programs are required to include the teaching of communication skills in the formal curriculum [10,11] and the curricular content for teaching and assessment of communication skills has been described in the literature [12–24].

In undergraduate medical education (UME), explicit curricular time for these topics is often provided only in the pre-clerkship years [25] at a point when students' medical knowledge and patient care opportunity are still minimal. Although communication skills are sometimes taught in the context of lectures, students prefer more experiential techniques for learning, such as role-play with standardized patients [26], and it is recommended that more experiential methods should be used [27]. Adult learning theory

* Corresponding author at: New York-Presbyterian Hospital, Graduate Medical Education, 525 E. 68th Street, Box 312, New York, NY 10021, USA.
Tel.: +1 212 746 4055.
E-mail address: Lyk2003@nyp.org (L. Konopasek).

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with its focus on experiential learning [28] suggests that moving the explicit teaching of communication skills into the clerkship years, when it is more relevant to the students' level of medical knowledge as well as to their daily activities, should enhance its impact on the learner. A recent study demonstrated that physicians' selection of communication behaviors is situational and goal driven and thus training in specific skills selection could improve communication in practice [29]. However, in the clerkship years, students report that they learn communication skills informally, mostly through trial and error in clinical practice with little direct observation and feedback, and that learning often does not reinforce the formal teaching of the pre-clerkship years [30].

Medical students' interpersonal and communication skills can decrease during the course of medical school [31–33]. Similarly, it has been shown that students' empathy and patient-centeredness declines in the clerkship years [34,35]. Variably skilled residents and faculty members may model poor communication skills through the hidden curriculum [36] and may implicitly portray the cultivation of these skills as intellectually "soft". Also, some students have negative attitudes toward learning communication skills and feel that they do not need to improve them [31]. The failure to connect the skills needed for effective physician–patient communication to the clinical reasoning process and the potential to enhance diagnostic accuracy, may contribute to this perception of a lack of intellectual rigor. Clinical reasoning is seldom integrated into the teaching of communication skills but the two can add value to each other when taught together [37]. Thus, we used the modified Calgary-Cambridge guide [16,38], which deliberately places communication skills teaching into the context of clinical skills development by focusing on both the process and content of communication [38].

The Objective Structured Clinical Examination (OSCE) has become a widely-used and successful methodology for summative and formative assessment [39,40]. However, the multiple-station OSCE format for individual students is time-intensive. Furthermore, some OSCEs such as the USMLE step 2 Clinical Skills (CS) licensing exam are designed for summative assessment of minimal competency. The minimal competency assessment may contribute to the notion that communication skills are low-level requirements to be passed rather than sophisticated skills to be developed through life-long learning in practice.

This paper describes the Group Objective Structured Clinical Experience (GOSCE), a novel educational format for teaching communication and clinical reasoning within the clinical clerkships that may address many of the challenges described above. The GOSCE's application in our sessions is to provide formative rather than summative assessment as in the GOSCE construct introduced by Biran [41] and Elliot [42]. The "E" of our GOSCE stands for "experience" rather than "examination" and is designed to teach and evaluate communication skills in the context of clinical reasoning and reflective practice [31], explicitly linking these domains with the goals of improving diagnostic accuracy, promoting more accurate self-assessment, and motivating ongoing learning.

It has been suggested that adult learning theory is useful in developing clinical reasoning curricula, including a focus on experiential learning and active problem solving with a more experienced "coach" to guide this process [43]. It is now recommended that students should be taught to use a dual processing system, deliberately shifting between, type 1 thinking (i.e. intuitive or pattern recognition) and type 2 thinking (i.e. analytic). [43–45]. We structured the embedded clinical reasoning exercises in our GOSCE to prompt this shift between pattern recognition and hypothesis testing; a skill thought to be important in decreasing cognitive biases [46]. Problem representation, the summary of the clinical picture which physicians use in oral and written communication between each other, has been described as an essential skill for the demonstration of effective clinical diagnostic reasoning [47] and its use in case presentations may lead to more effective learning and diagnostic ability [47]. Students used problem representation in the inter-provider communication embedded in each GOSCE case.

The GOSCE was also designed to promote high quality, collaborative, detailed and immediate feedback from the instructors, SPs, and peers, and to encourage the development of the skills of self-assessment and reflective practice. Feedback, effective self-assessment and reflective practice are all thought to be critical to self-directed, life-long learning, the development of clinical competence, and the provision of quality care to patients [31]. Self-assessment and reflective practice are especially important in developing competence in communication and interpersonal skills, because most learning occurs in the context of independent practice with little feedback provided by patients.

Much has been written on the inadequacies of self-assessment by physicians, with self-assessment being neither valid nor accurate and with the lowest accuracy occurring in the least competent physicians [31]. However, physicians do have the capacity to achieve concordance with the patient's view of the physician–patient interaction [48] and self-assessment can be more accurate if it is focused on on-going monitoring of behavior [47] and specific evaluation criteria are provided [49]. Furthermore, developing self-assessment skills during medical school may improve these abilities later in training [47]. Our method of observation and learner self-assessment, followed by group feedback, was designed to help calibrate the learner's judgment of their performance [50]. The immediacy of external feedback after the self-assessment may increase a learner's capacity to improve self-awareness and change performance [51], and draws on the model of developing expertise through deliberate practice and feedback [52]. Furthermore, the feedback from three different sources (peer, SP, and faculty) combined with self-assessment began to approximate a multi-source feedback approach now commonly used in graduate medical education (GME) [53].

The purpose of our paper is to describe the GOSCE technique for teaching communication skills in the clinical reasoning context and to demonstrate the feasibility of this approach in a pilot study. Our evaluation methods focus on three components which have all been tied to increased motivation of students to learn: (1) self-efficacy, or belief in their ability to perform a task, (2) value, or belief that the task is important, and (3) affective component, or positive emotion to a task [54]. Our long-term goal is for the GOSCE to motivate ongoing learning of communication skills in clinical practice, outside the classroom or clinical skills lab.

2. Methods

GOSCEs focusing on development of communication skills in the clinical reasoning context were developed and implemented in the Medicine and Pediatrics clerkships at a U.S. medical school. Students were surveyed on the acceptability of this method and changes in self-efficacy.

2.1. Participants

The learners were third- and fourth-year medical students at the midpoint of either a 12-week Medicine clerkship or 6-week Pediatrics clerkship. Participation in the GOSCE was a requirement of the clerkship. Participation in the post-training GOSCE evaluation survey was voluntary and was approved by the Weill Cornell Medical College Institutional Review Board (IRB).

SPs used for the Pediatric GOSCE were acting students in their early 20s who had not had a previous SP experience. The SPs