Tailoring to educational needs: preparatory studies into doctor-patient communication training and the development of trainers’ expertise in general practice specialty training

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Citation for published version (APA):
van Es, J. M. (2012). Tailoring to educational needs: preparatory studies into doctor-patient communication training and the development of trainers’ expertise in general practice specialty training.
CHAPTER 1

General Introduction
Tailoring to educational needs

General Introduction

This thesis describes two series of studies conducted at the Institute for General Practice (GP) Specialty Training of the Academic Medical Center, University of Amsterdam, into the preconditions for implementing tailored educational programmes. The first series examined the possibility of assessing trainees at the start of their training in order to tailor doctor-patient communication training to their needs. The second series of studies investigated ways to optimize conditions for the individual development of GP trainers’ expertise.

Background

In 2007, the Institute for GP Specialty Training of the Academic Medical Center formulated a new mission statement. The Balanced Scorecard (BSC) – a management system that is widely used in the commercial and non-profit sector – was applied to transform the strategic goals of the mission statement into critical success factors.1 In this process, we defined tailoring our training to the educational needs of both trainees and trainers as a critical success factor. The impact of the adjustments we would have to make in order to tailor our GP training to trainees’ and trainers’ educational needs was expected to be quite substantial. We therefore decided first to study the preconditions for tailored education within the context of GP specialty training.

Tailoring to educational needs

Education underwent a shift in the late 20th century from a mainly teacher-centred approach to a predominantly learner-centred approach.2,3 The central tenet behind the learner-centred learning theory is that both adults and children learn best when they encounter topics that puzzle them, as this motivates them to acquire the knowledge and skills required to solve the puzzles. However, society increasingly demands that professionals and organizations account for their performance. For educational institutes that means engaging in quality assurance and providing insight into their learning outcomes.4,5,6 Performance indicators are formulated for educational institutes and competency profiles are drawn up for a growing number of professionals, not in the least those in the medical field. To acquire all the knowledge and skills set down in these competency profiles, one’s learning activities cannot be restricted to puzzling topics. Some guidance is needed to ensure that expectations on outcomes are...
met. In practice, learner-centred learning in higher (medical) education entails helping learners to find the best way to acquire the knowledge and skills defined in the competency profile of the study they are following.\textsuperscript{7,8} A prerequisite for acquiring the competencies is knowledge about the current level of competence. The assessment of learners’ competence in post-graduate medical training has been a popular topic for research.\textsuperscript{9-11} Informed self-assessment fits best within a learner-centred approach.\textsuperscript{12} It comprises comparing external judgement of one’s competence with one’s own judgement. In a learner-centred approach, one’s own judgement is vital to attain the intrinsic motivation to learn – the central tenet behind learner-centred learning. Comparing external judgements with self-assessment circumvents the lack of accuracy and reliability of professionals’ self-assessments and, more importantly, allows the learner more easily to incorporate and accept feedback from others.\textsuperscript{13-15} Informed self-assessment is preferably presided over by a facilitator who discusses learners’ feedback reports, which include multi-source feedback and self-assessment. The use of a facilitator serves various purposes: it helps to make learners aware of discrepancies between self- and external judgements, it can ease learners’ acceptance of less positive feedback, and a facilitator can coach learners to address their educational needs by, for example, discussing their portfolio or personal development plan (PDP).\textsuperscript{16,17}

**Local context**

GP speciality training in the Netherlands is a 3-year programme provided by the country’s eight academic medical centres. The Institute for GP Speciality Training of the Academic Medical Center, University of Amsterdam, tutors 72–80 GP trainees each year. Trainees spend their first and third years in a GP training practice under the supervision of a licensed GP trainer. In the second year, they have rotations in clinical settings, psychiatric institutions or out-patient clinics (e.g. nursing homes). One day a week they follow modular courses at the institute.

GP trainers who successfully complete the 4-year programme of eight course days per year are considered fully qualified. These GP trainers then enrol in modular courses for experienced GP trainers. GP trainers are evaluated twice a year by their GP trainees. The results of these evaluations and the trainers’ observed commitment during the modular courses are discussed in annual evaluations with a staff member of the institute.
Tailoring to educational needs

**Tailoring to educational needs in doctor-patient communication**

Communication is an important aspect of GP consultations. The quality of this communication has a considerable impact on diagnostic accuracy, the patient’s adherence to therapy, and the patient’s and the doctor’s well-being. The training of doctor-patient communication skills therefore has a prominent place in GP speciality training. The effectiveness, however, of training doctor-patient communication skills is a matter of debate.

As anyone involved in the training of doctor-patient communication will confirm, the skilfulness in, and probably also the learnability of, doctor-patient communication differs considerably among trainees. Tailoring doctor-patient communication training to the educational needs of individual trainees might therefore be a way to improve both the outcome and the efficiency of such training. However, we are not aware of any institute that has adopted this approach.

We know from other studies that such variables as personal characteristics, previous training experience, reflective thinking, emotional intelligence and knowledge of doctor-patient communication skills, correlate with doctor-patient communication skills, and we used these insights in the present studies. In the first study (Chapter 2), we explored the dimensional structure of the instrument we use to assess the doctor-patient communication skills of our trainees, that is, the MAAS-Global rating list for consultation skills (MG). We studied the dimensional structure of this instrument to see whether the various doctor-patient communication skills could be clustered according to a meaningful concept.

In the second study (Chapter 3), we looked at the differential growth in the doctor-patient communication skills of first-year GP trainees and whether there was a link to the clusters we found in the first study. In the third study (Chapter 4), we analysed what predicts GP trainees’ skilfulness in doctor-patient communication at the end of the first year, based on an assessment of personal characteristics, knowledge and skills at the start of that training year.

**Tailoring to the educational needs of GP trainers’ personal development**

Workplace-based learning constitutes the major part of GP speciality training. As GP trainers occupy a central role in this, their competencies as teachers are inextricably bound up with the quality of the outcome of GP speciality training.
The implementation of a 4-year GP trainers’ programme at our institute in 2006 represented an important step forward in anchoring the quality of GP trainers. Completion of the programme results in qualifying as a GP trainer. However, monitoring the quality of trainers should be an on-going process. Although all GP trainers at Dutch GP training institutes are evaluated twice a year by their trainees and this is discussed in annual meetings with a staff member, GP trainers’ use of this feedback for their personal development is not monitored. If we want to tailor the training of our GP trainers to their educational needs, it is important to know whether they are capable of using the feedback they receive from trainees to define their educational needs and to develop further as GP trainers. We therefore investigated which type of feedback GP trainers use to define goals in their PDPs (Chapter 5). We supplied them with the feedback scores and narrative comments of their trainees together with the scores on their self-assessment. This combination of feedback from trainees and the self-assessment paved the way for informed self-assessment, discussed earlier as fitting in a learner-centred approach. Feedback and self-assessment scores were elicited through questionnaires that followed the four main categories of the competency profile for the GP trainer, namely GP-related medical expertise, teaching skills, accommodating trainees and personal functioning.

We subsequently studied how well GP trainers were able to draw up their PDPs by evaluating the SMARTness of their PDPs (Chapter 6). We were particularly interested in ways to improve the quality of the PDPs. We therefore investigated two interventions by randomizing the GP trainers either to a peer group presided over by a staff member or to a practice visit conducted by a staff member, and then evaluating whether discussing the action plans in a peer group led to a similar improvement in the quality as discussing them with a trained staff member, considering that the latter is less costly due to a larger demand on staff working time (Chapter 6).

Outline of this thesis
We discuss the concept of tailoring to educational needs in Chapter 1. In Chapters 2-4, we present our studies on doctor-patient communication, starting in Chapter 2 with the dimensional structure of the instrument we used to assess the doctor-patient communication skills, namely the MAAS-Global Rating list for consultation skills.

1 SMART acronym stands for Specific, Measurable, Accepted, Realistic and Time-bound
In Chapter 3, we describe the growth in the doctor-patient communication skills of first-year GP trainees during the current training programme, and discuss the different growth patterns detectable in our results taking into account the dimensional structure discussed in Chapter 2.

Chapter 4 builds on the results of Chapters 2 and 3 and discusses what best predicts the level of doctor-patient communication at the end of the first year of training. If we are able to predict the current end-level of doctor-patient communication skills, it will help us to establish which trainees need additional training and which trainees need less training or, alternatively, a more challenging programme.

In Chapters 5 and 6, we focus on our studies on the use of feedback by GP trainers. In Chapter 5, we discuss which feedback and self-assessment scores GP trainers use in developing their PDPs. In Chapter 6, we compare the SMARTness of the PDPs written by the members of the practice visit group with that of the PDPs of the members of the peer group. Given that GP trainers can identify their educational needs and operationalize them in PDPs, it could open the door to introducing tailored education for GP trainers that is directed at the learning goals described in their PDPs. In Chapter 7, we discuss the results of our studies and their implications for the tailoring to educational needs in GP specialty training.
References

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