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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CHAPTER 7

General Discussion
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Introduction to the general discussion

The central aim of this thesis was to provide general practice (GP) specialty training institutes with evidence-based insights into the preconditions needed to implement tailored educational programmes.

We obtained such insights by performing two series of studies in two specific contexts within GP specialty training, namely our doctor-patient communication training programme and the individual development of our GP trainers. We reported on the results of these studies in the previous chapters. In this general discussion, we discuss our findings and their meaning for tailored education in GP training and, where possible, in higher education in general.

Tailoring in doctor-patient communication training (Chapters 2–4)

Introduction

Learners skill levels differ when they start their programmes. Additionally some find it harder or easier to acquire certain skills.\textsuperscript{1,2} Institutes for higher education should therefore invest in tailored educational programmes. To tailor a programme, one first needs to know what to tailor upon and who needs a tailored programme.

In the doctor-patient communication training programme at our institute, staff-members observe considerable differences in skilfulness in doctor-patient communication amongst first-year GP trainees. To be able to deal with these differences, we needed more knowledge of the trainees’ doctor-patient communication skills level before and after their training and of the predictability of these skills.

To assess these doctor-patient communication skills, we used the MAAS-Global rating list for consultations (MG), which is the most commonly used, validated instrument in GP training in the Netherlands.\textsuperscript{3–5} The MG can be used to assess 13 doctor-patient communication skills. However, to tailor educational programmes, differentiating on the skills level was considered too specific. We therefore investigated whether the individual skills could be adhered to an underlying construct by exploring the dimensional structure of the MG. We subsequently studied the extent to which we could predict doctor-patient communication level both before and after skills training. We used these
predictors to differentiate between trainees’ individual needs in doctor-patient communication training, and consequently the need to tailor their educational programmes.

**Key findings and interpretation**

In our first study (Chapter 2), we found a two-dimensional structure containing a cluster of patient-oriented skills – that is, skills that are used to establish rapport with the patient (e.g. ‘exploring feelings’ and ‘empathy’) – and a cluster of task-oriented skills, for example such items as ‘structuring’ and ‘discussion of management plan’. A similar structure can be found in the work of Hall and Roter, who stated that the behaviour of doctors can be classified as either task-oriented or socio-emotional. It also resembles the framework of Kurtz and colleagues, upon which the widely used enhanced Calgary-Cambridge Guides for teaching and evaluating skills in doctor-patient communication are built. Kurtz discerns skills for ‘providing structure’ and skills for ‘building the relationship’.

Since the structure we found in the MG could be anchored in relevant theories on doctor-patient communication, we decided to use the resulting factors in our second study, which was on the growth in doctor-patient communication skills (Chapter 3). In this study, we found three growth patterns: (1) low baseline level and a relatively high follow-up level, (2) moderate baseline level and moderate growth, and (3) quite high baseline level and no or only slight improvement. Patient-oriented skills more closely follow either the first or the third pattern, while the task-oriented skills follow the second pattern. However, these patterns are not indicative for tailoring when required standard scores are taken into account. Differences between required and attained scores are too diverse within both patient-oriented skills and task-oriented skills. We therefore suggest that the aspects to tailor upon should be derived from the scores at item level.

We also found that the percentage of trainees who attained the standard score required at the end of the 3-year GP training (an average of the percentages attained for each of the 13 items) was 16 per cent at baseline and 43 per cent at follow-up. Based upon this, we can say that although GP trainees learn a lot in their first year, 57 per cent will still need to improve substantially in order to attain the standard score at the end of their training. First- and third-year
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GP trainees work in GP practices, while in their second year they do clinical rotations. Since doctor-patient training in the third year focuses on context-specific situations and techniques – for example, motivational interviewing or cognitive behavioural treatment techniques – the basic skills should predominantly be acquired during the first year. Getting back to the 57 per cent who have not attained the standard score for graduated GPs, we can assume that at least some of them might benefit from extra attention regarding their doctor-patient communication training.

Moreover, the 43 per cent of trainees who had attained the standard score might need either less of the regular training or need to be challenged in another way, and as such should have their own tailored programme.

In our last study, we found that one third of the predictors (age, gender, knowledge of doctor-patient communication skills, emotional intelligence, reflective skills and doctor-patient communication skills in OSCEs as measured before the start of the training) had moderate correlations with doctor-patient communication skills in real-patient consultations recorded before the doctor-patient communication training started. However, almost all correlations weakened substantially when doctor-patient skills at the end of the first year were predicted. The clear exception to this was reflective skills, which showed a stronger correlation with doctor-patient communication skills after the training. The level of doctor-patient communication skills before training, as shown in the real-patient consultations, was also a good predictor of these skills at the end of the training, although this of course is not surprising.

Although we carried out our studies in the specific context of doctor-patient communication, the relationship between reflective skills and learning is not context-specific and has been widely incorporated as an essential element in learning theories.\(^8\,^9\) The importance of reflective skills is nested within the learner-centred approach promoted by Dewey and Rogers, and is also an essential component of Kolb's learning theory.\(^10\,^11\) Schön introduced the term ‘reflective practitioner’, which fits well within higher educational settings that are characterized by workplace-based learning.\(^12\,^13\) Tagawa recently provided evidence on the positive effect of reflection training on OSCE scores.\(^14\) In learning specific skills like doctor-patient communication skills, one's reflective skills might be decisive because they might correlate with one's ability to learn, and we wonder whether instead of just focusing on training specific skills, the training should also address the reflective skills needed to profit from
the training of doctor-patient communication skills. The assessment of the differentiated skills also identifies which skills need more or less attention in a tailored educational programmes.

**Practice implications for educational settings**
The finding that reflective skills are predictive had not previously been found in the context of doctor-patient communication. This opens the door to differentiating in and perhaps even selecting upon potential skilfulness in doctor-patient communication after training with an easy and cost-effective tool. As such, it could help us to determine who might profit from a tailored communication programme. However, determining the skilfulness in real-patient consultations seems the best way to establish which doctor-patient communication skills need more focus in a tailored programme.

**Comments upon research method and further research**
We used an exploratory factor analysis in a one-institution group of trainees in consultations with simulation patients to establish the dimensional structure. A confirmatory factor analysis should be carried out, preferably with a larger group of trainees from different institutes and with real-patient consultations, to confirm this dimensional structure.

We had a considerable loss to follow-up. However, our findings on overall growth in communication skills are confirmed by Reinders and colleagues, who studied in a similar group at another GP training institute.\(^{15}\) As we do not know the extent to which our loss to follow-up influenced scores on the individual skills, a replication of our study with more participants is therefore recommendable. More participants might also have made it possible to construct a predictive model that has several predictors. It might also have enabled us to differentiate between the predictive value of our studied predictors on patient versus task-oriented skills.

Furthermore, to assess reflective skills we used an adapted scoring instrument for case vignettes based upon Boenink’s instrument.\(^ {16}\) Although it is an elegant and simple method that is applicable to different case vignettes, this instrument has not yet been validated and the robustness of our findings would increase were its validity established.

Last but not least, we were not able to include a control group to establish which part of the growth in doctor-patient communication skills resulted from
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the training and which part was spontaneous growth through working in a GP practice.

Optimizing conditions for the individual development of GP trainers (Chapters 5 and 6)

Introduction

In the field of continuing medical education, 'self-developmental activities' – are commonly guided by individuals own perception of learning needs. Reflection upon feedback in combination with self-assessment, preferably with the help of a facilitator (directed self-assessment) is recommended. At our institute, GPs must follow a 4-year programme to become qualified as GP trainers. They then attend obligatory modular courses to keep up to date as trainers. The trainers host one GP trainee a year in their training practices and are evaluated twice a year by that trainee. The results of this evaluation and of their input in modular courses are discussed at biannual meetings with one of the institute’s experienced staff members. However, both the quality and the effect of these activities are questionable. We therefore launched an ambitious programme to improve the situation.

GP trainers were asked to complete a self-assessment scoring list. This, together with their trainees' biannual evaluations (which include narrative comments), facilitated directed self-assessment, which has been found to enhance the assimilation of feedback. We subsequently asked them to draw up a personal development plan (PDP), which is a well-known method to stimulate self-development. We randomized the trainers to participate in either practice visits by staff members or in peer groups to discuss their PDPs. They then adjusted their PDPs and we investigated whether the two forms of participation had had a similar effect on the quality of the PDPs. Peer groups of three or four GP trainers presided over by a single staff member would lead to a major reduction in the number of staff hours consumed compared to practice visits, and we deduced from the literature that peer groups could be at least as effective in providing feedback.

Key findings and interpretation

Of the GP trainers, 93 per cent submitted PDPs and more than 75 per cent of the action plans in these PDPs were based on feedback. The trainers were
keen to address feedback on their GP-related expertise but not that on their personal functioning. This is something we should work on, since personal functioning is related to being a good role model, which is an essential element in the still rather classic master-apprentice construction in GP training.24 When the different types of feedback pointed in the same direction, the feedback was more often used. This was especially so if narrative comments were included. This calls for maximizing the number of feedback sources and intensifying the options for narrative feedback.

The quality of the PDPs increased to a similar degree in the peer groups and among those randomized to practice visits, although the percentage of revised PDPs submitted by those in the peer groups compared to those in the other group was slightly higher. That peer groups can help teachers to reflect upon and formulate PDPs was reported in a study by Boerboom and colleagues.25 That the effect of discussion in peer groups on the quality of these PDPs is comparable to that of a time-consuming one-on-one practice visit, is additional knowledge provided by our study.

We developed for this study an instrument to assess the SMART-criteria (SMARtness) of the PDP goals. Although some publications have addressed goal-setting abilities26,27 to our knowledge ours was the first study to systematically assess goal-setting abilities.

Since the use of PDPs is not limited to the educational setting, we assume that looking more closely at goal-setting abilities might also be interesting for other contexts.

Practice implications for educational settings
In guiding personal development activities in any continuing (medical) education setting we recommend: 1) facilitating structured feedback programmes that elicit feedback from multiple sources in the form of both narrative comments and quantitative feedback; 2) helping individuals to take into account all of their feedback; and 3) coaching in the drawing up of PDPs, preferably by discussing them in peer groups since this is cost-effective.

Comments upon research method and further research
It took a great deal of effort to get GP trainers to write PDPs even in a research setting, and in a real-life context these efforts might not be reproducible. On the other hand, the process was new to our trainers and, in time, when it has
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become imbedded in practice, it might require less effort. Further research should focus not only on the goal-setting qualities we studied, but also on gaining knowledge of the substantial quality of the action plans. Whether PDPs contribute to competency development should also be studied.

Final comments

Our research has provided insights into several preconditions for implementing tailored doctor-patient communication training on which we can further build. Regarding our GP trainers, it has generated insights into how to optimize tailored activities concerning their individual development through the implementation of PDPs.

References


