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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Summary
Tailoring to educational needs

This thesis describes two series of studies conducted at a GP Specialty Training, investigating the preconditions needed to implement tailored educational programmes.

First series of studies
The aim of the first series of studies was to investigate whether the doctor-patient communication skills of GP trainees can be predicted at the end of their first year, based on assessments made at the start of their training, in order to tailor the doctor-patient communication training to their individual needs.

We started by investigating what skills to base the tailoring on. We therefore needed to establish the GP trainees’ current levels of doctor-patient communication skills. The most commonly used instrument in Dutch GP training to assess such communication is the MAAS-Global rating list for consultation skills (MG). The MG comprises 13 items on doctor-patient communication. Since tailoring according to items is a very detailed process, in our first study (Chapter 2: Two-dimensional structure of the MAAS-Global consultation skills rating list) we investigated the underlying dimensional structure of the MG with an exploratory factor analysis of the data on 68 first-year trainees, who were assessed in a two-station OSCE. We subsequently explored the validity of this structure by studying the relationship between the MG subscales and the (personal) characteristics of the GP trainees. Two well-interpretable factors were found, representing patient-oriented and task-oriented communication skills. Being a native trainee and empathy were positively associated with overall communication skills. Prior communication skills training was exclusively related to task-oriented communication skills. Empathy was associated with patient-oriented, but not with task-oriented communication skills.

In our second study (Chapter 3: Differential growth in doctor-patient communication skills in GP trainees), we investigated the growth in doctor-patient communication skills in first-year GP trainees both on skills level and on the patient-oriented and task-oriented factors. Of 29 GP trainees six real-patient consultations were analysed with the MG at both the beginning (baseline) and the end of their first year (follow-up). The scores showed a significant growth in all items but one. Patient-oriented skills showed significantly more growth than task-oriented skills, and there were considerable differences in growth pattern between individual items. Empathy as a separate skill seemed to be mastered predominantly before the start of training.
Three patterns in the growth in skills were distinguished: 1) low baseline, relatively high follow-up, 2) moderate baseline, moderate growth, and 3) high baseline, hardly any growth. Patient-oriented skills follow pattern one or three, while task-oriented skills follow pattern two. However, these patterns are not indicative of tailoring when the required standard scores are taken into account. Differences between required and attained scores are too diverse within both patient-oriented and task-oriented skills. We therefore suggest that the aspects according to which the training is tailored should be derived from the scores on the item level.

In the third study (Chapter 4: Can we predict future doctor-patient communication skills on the basis of personal characteristics, knowledge, reflective skills and current communicative skills?), we investigated the extent to which the skilfulness of our group of 29 GP trainees in doctor-patient communication before and after completion of the standard 9-month training programme, could be predicted by their personal characteristics, knowledge, reflective skills and communicative skills as assessed before the start of their training.

One third of the predictors had medium sized correlations with skills at the start of the training. At the end of the training, only pre-training doctor-patient communication (.49) and reflective skills (.40) still showed medium sized correlations. The correlation with reflective skills had increased. We concluded that good reflective skills contribute to the acquisition of doctor-patient communication skills. Characteristics related to lesser skills at the start of the training – such as being male, being older and having less knowledge – can be compensated for by training. To tailor doctor-patient communication training, both the initial skill level and reflective skills should be taken into account.

Second series of studies
The aim of the second series of studies was to investigate how we could optimize conditions for the individual development of GP trainers’ expertise. Individual development is currently stimulated through evaluation meetings between individual GP trainers and a staff member, during which the trainer’s input in the obligatory modular courses for GP trainers and the results of his/her biannual evaluations by the GP trainee are discussed. To invest more in the quality of these activities, we wanted to introduce personal development plans (PDPs).
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Therefore in our first study (Chapter 5: Do GP trainers use feedback in drawing up their personal development plans?), we investigated the feedback usage by GP trainers in drawing up their PDPs. GP trainers were provided with three feedback sources: trainees’ rating scores, trainees’ narrative comments and self-assessment scores. Trainers were instructed to use these while drawing up action plans for their PDPs. We used quantitative analyses to determine the extent to which feedback sources were used.

Of the trainers, 93% submitted a PDP. More than 75% of their goals were based on provided feedback. Multiple sources pointing in the same direction increased feedback use. If two or more sources pointed in the same direction, feedback was used more often if one of them concerned ‘narrative comments’. Ratings were lowest for GP-related expertise and teaching skills. Most of the goals defined were related to these domains. Fewer goals were related to personal functioning. The proportion of feedback on personal functioning that was used by the trainers was the lowest.

We concluded that GP trainers base their goals mostly on the feedback they had received and that they address the issues that are most commented upon. We also concluded that narrative comments deserve a profound place when eliciting feedback.

It would be most practical to incorporate discussing PDPs in the existing annual evaluation meetings between individual GP trainers and a staff member. However, this would put a high demand on resources. Therefore in our second study in this series (Chapter 6: SMART, SMARTER, SMARTEST: the influence of peer groups compared to practice visits on the quality of action plans), we investigated whether feedback from a peer group (PG) – which would put less strain on resources than feedback from a staff member during a practice visit (PV) – is as effective in improving the quality of action plans.

Seventy-three GP trainers randomized to either a PG or a PV group were instructed to draw up action plans using the SMART-criteria that would lead to the realization of the goals set in their PDPs. To improve action plans, feedback was given in either a PG or during a PV. We used a study-specific instrument to assess the quality of baseline and follow-up action plans, operationalized as the SMARTness with which plans were formulated.

The response rate for submitting both baseline and follow-up action plans was 89% in the PG versus 79% in the PV group. It was feasible to determine scores on all SMART-criteria, except for the criterion ‘acceptability’. A significant
improvement was made on the remaining four criteria irrespective of the feedback setting.

We concluded that PGs cost less and seem equally effective in improving the SMARTness of action plans. They also seem to provide GP trainers with more stimulation to write PDPs. They therefore may be favoured over PVs.