Meeting the Students on Their Own Territory

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Abstract

Background
Medical students receive communication skills training but there is little research into how effectively, or indeed whether, these skills can be transferred into clinical settings. This paper reflects upon a project aimed at supporting students in communicating with patients in clinical settings during their undergraduate years.

Method
During 2012, 36 year medical students were directly observed leading consultations with real patients in in-patient settings by a communications skills expert. Each observed session involved focused feedback on performance and agreeing areas for future practice involving a student peer and the member of faculty.

Results and Discussion
Students positively evaluated this work-based experience, specifically, valuing the authenticity of engaging with 'real patients' in 'real settings'. They reported learning to deal with environmental issues such as noise, interruptions – the hallmark of busy clinical settings. They gained from observing the Communication Skills teacher model effective communication within the consultation process and receiving immediate focused one-to-one feedback. Moreover, they were able to maximise the feedback through immediately applying it to further consultations. The challenges of rolling out such a programme to more students are discussed.

Implications
Observed practice in work-based settings helps students to recontextualise knowledge learnt in the classroom setting. Their learning is greatly enhanced by having the supported opportunity to apply their skills in an authentic setting. However, implementing such a project can be resource intensive and logistically challenging.

Keywords: communication skills, work-based learning, feedback

Research indicates that teaching communication skills can lead to improvement in practice and patient satisfaction (Lienard *et al.* 2010). Heaven *et al.* (2006) reported that although training does have a positive effect on skills, the transfer of these skills does not take place without enabling support in the workplace, and others have identified the need to close the theory–practice gap (Silverman & Wood 2004, Malhotra *et al*. 2009, Brown 2010).

As a Communication Skills Lecturer with a clinical background it was my intention to develop a workplace initiative for medical students and this paper is a reflection on the experience. Although not a new subject, the focus of the article is on the developmental process, the benefits and challenges and thoughts about ways forward. My initial aim was to collaborate with NHS Trust colleagues to encourage clinicians to observe students eliciting histories and to give feedback. However, it soon became clear that despite their support in principle, clinicians felt unable to give time themselves but were happy for me to come into the workplace to facilitate sessions. This resulted in limiting implementation of the project to just one firm and carrying out all the observations single-handedly.

Consequently in 2012, I undertook 18 teaching sessions, each two hours in length, with pairs of third year medical students. I observed 36 of the 360 year cohort as they elicited histories from ward patients. Queen Mary University of London ethics committee deemed ethical clearance to be unnecessary for this evaluative study.

The aim was to support the student to achieve an effective interaction with the patient in terms both of empathy and of information gathering. Feedback on performance, aided by the completion of a feedback form (see Appendix), was given by me and the student peer. This developed the latter's feedback skills (Perera *et al*. 2010). Patients also gave feedback.

A conceptual model of formative assessment described by Sadler informed my approach to feedback (Sadler 1989). In order to develop, students need to:

1. possess a reference point to aim for;

2. be able to compare their current level with that reference point; and

3. engage in appropriate action in order to close the gap.

Students were initially asked to draw on knowledge and skills which they had learned in the classroom to construct their personal interpretation of the task. They then went to meet and talk to the patient. As I observed them, I would often identify a key moment when I could helpfully intervene and model a skill. Subsequent debriefing involved the student reflecting on feelings, skills and the extent to which their performance was in line with the aim of their consultation, with thoughts on action points to bridge any gap.

The students evaluated the sessions, completing a questionnaire containing three open questions: what they had learned, suggestions for improving the session, and how it compared to other communication skills learning experiences. Using Framework Analysis (Ritchie & Spencer 1994) responses were filtered down to four major themes. These were the value of

• practising in an authentic environment;

• receiving specific and immediate feedback on communication;

• the opportunity to practise and implement feedback immediately;

• learning skills other than communication during the session.

These findings are consistent with features reported in the literature on the value of opportunistic and guided learning in the workplace. It can, however, be difficult to assess students' competencies as a result of this learning, given that it is part of a developmental process of professionalism (Jha *et al.* 2012).

To extend this teaching I subsequently involved 15 junior doctors interested in teaching who were keen to gain experience for their career development. They observed my facilitation and then I observed them, giving them written feedback for their portfolios. They then began observing students themselves. Sustaining this initiative can be difficult, although one junior doctor with the support of her consultant has set up a rolling programme as part of the junior doctors' educational plan.

The project provided students with the opportunity to practise, gain feedback and consolidate their communication skills with real patients who presented a variety of responses and challenges. Unpredictable issues arose and students learned how to handle these with support but without the benefit of time out or discussion, e.g. patient crying.

Students seemed to value the patient feedback when provided, over and above that which I or their peers gave them. They reflected on professionalism, how they make assumptions, what patients say make good doctors and things that we do not always emphasise in the classroom, such as dealing with interruptions and noise. Students were not simply transferring knowledge from the classroom but having to use it in real life contexts. They were 'recontextualising' their skills (Evans 2011) within a workplace setting. For my part, the project has been a powerful influence in enriching my classroom teaching, which could be valuable to other communication skills lecturers.

In the course of recruiting new clinicians, I reflected that in implementing such a project there could be tensions between quality of facilitation versus quantity of students observed. In order to maximise the number of students who might benefit, one course of action would be to incorporate the project directly within the curriculum. The downside may be that by expecting clinicians to observe the students, more students might be observed but without conviction it might turn this into a 'tick box' exercise. The advantage of our 'grass roots' approach, using clinicians who volunteer for the project, is their enthusiasm for communication skills learning in the workplace.

Whilst logistically challenging I have seen the value of following my students into the clinical areas for communication skills learning and of supporting clinicians keen to take part. The facilitation model has enabled collaboration between medical schools and the clinical areas. The next steps are to encourage further collaboration, such as developing clinicians as teachers and facilitators and supporting academics who teach communication skills but are unfamiliar with the challenges of the ward environment, to meet students on their own territory.

Appendix Feedback Sheet

Observer………………. Role……………. Date………..

Eliciting a history of presenting complaint
Feedback sheet

	Aspects done well	Areas to improve
1. **Relationship**		Name and role.
		Explains purpose of interview, note-taking.
Introduction and orientation rapport and Empathy		Confirms patient's comfort/ agreement.
		Welcoming manner.

(Continued)

	Shows interest, respect and concern.
	Appropriate body language (eye contact, seating etc.).
	Acknowledges patients' feelings and concerns when expressed in the interview.
2. **Exploring the problem**	Uses open questions initially to explore and listen, following up later with focused and closed questions for detail.
Questioning skills	Uses screening questions 'Anything else?'
Listening skills	Avoids leading questions or complex questions.
	Listens attentively without inappropriately interrupting.
	Responds to patient's answers.
	Picks up on patient's cues (verbal and non-verbal).
3. **Summarises history of presenting complaint**	Summarises back to patient.
	Clarifies and checks for accuracy and completeness.
4. **Content and clinical reasoning**	Gets a clear and accurate account of history of presenting complaint.
	Covers areas of questioning that are relevant to diagnosis and differential diagnosis.

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