Unraveling postgraduate communication learning: from transfer to transformative learning

Valorisation

This valorization chapter provides directions for creating value from the research work reported in this thesis.

The point of departure of this thesis is the global concern about poor doctor-patient communication, despite ample educational efforts. Much effort and finances are invested in communication skills training in medical schools around the world with only marginal effects on clinical communication in daily practice [1-4]. A majority of patients' complaints about health care still addresses poor communication skills [5] such as poor explanation, misunderstanding or no understanding at all, and - consequently - suboptimal cooperation by the patient in the management of their disease or their life-style [6]. In other words, poor doctor-patient communication is linked to considerable loss of well-being, decreased satisfaction and decreased adherence to treatment plans and medication [7-11], and increased financial costs [12].

The approach to this problem so far has been to increase the amount of training, despite considerable evidence that this does not solve the issue [3].

In this thesis we address the problem from an educational view-point. Do the current forms of training establish enough transfer of learned skills from training to daily practice? And if not so, can we find evidence for recommendations that would likely lead to more effective forms of training and learning? When stating "more effective", we mean leading to lasting behavioral change at the work floor.

The value of this thesis is in the answers to these questions. We claim that we have found evidence for a more effective type of education, more awareness and better integration of doctor-patient communication in the daily work of the busy physician. The knowledge presented in the four studies of this thesis can serve as the basis for the development of guidelines for medical educators and policy makers to improve learning and working climates within medical departments to better support communication learning processes.

The research value of this thesis is captured by relating our main findings to five gaps in existing research. We refer to section 2 of chapter 6 for a more detailed description of the five gaps and how our results contribute to a reduction in each of the gaps.

The innovative value of this thesis is captured in our five-phase model (see table 1) which contributes to a current central theme in the field of communication skills learning and teaching by showing what process is needed to increase effectiveness and transfer of postgraduate communication skills teaching. Effective learning (or transfer to the medical workplace) of communication does not automatically ensue from communication skills training, especially not so when training is decontextualized or offered off-site. Instead, the results in this thesis might trigger medical educators and policy makers to start realizing that the communication learning process entails these five phases and can *only* occur successfully if the learner experiences enough emotional and cognitive space and safety, the two main conditions for learning mentioned in our

model. Only then will the learner feel safe enough to be confronted with his or her behaviour and allow reflection on it to become conscious of a blind spot, then try out and practice alternative behavior safely in practice, and personalize and internalize it to become fully integrated. We have found clear indications (provided by the stakeholders themselves) that such a type of 'education' is much more likely to lead to a lasting effect instead of or when combined with the current practice of isolated one-time training.

Table 1: The five phases and two overall conditions in residents' learning process of communication skills.

COGNITIVE AND EMOTIONAL SPACE				
Phase 1 Confrontation with the effect of a certain behavior	**Phase 2** Becoming conscious of own behavior	**Phase 3** Searching for alternative behavior	**Phase 4** Personalization of new behavior	**Phase 5** Internalization and clinical integration
SAFETY				

We hope that this dissertation will contribute to a shift in the way communication learning is envisioned. A shift toward viewing it more as a holistic and personal lifelong process of learning whereby medical work and learning environments can and should be adjusted accordingly to foster this learning process. The conception that learning is equivalent to lifelong personal development has important implications for practice and for the established model of competency-based education. Within hospitals and departments this paradigm shift entails a move toward a medical working culture in which it becomes normal to talk about how the profession affects you as a person and in which colleagues emotionally support each other more openly *when needed*. In this sense, professional medical associations and medical institutions carry the obligation to create better working conditions and provide programs that support such personal reflection and self-care.

On a practical level this support can be translated by implementing integrated peer sessions at departmental level to enable residents to pay continuous attention to their communication. These sessions offer space and support to discuss communication/emotional issues, such that doctors or residents feel less solitary and have the possibility to ask for tips or support when needed. These sessions can provide a safe and nurturing environment within a department, which is needed to truly perform all 5 phases of the communication learning process.

In other words, this thesis suggests supplementing competency-based education programs with structured time for residents to pay attention to communication issues and the deeper levels of learning as part of their personal and professional development, instead of focusing on isolated training programs and lists of rules and behaviors to capture the CanMEDS competency of communication skills.

This thesis offers four practical points of attention to take into account when departments consider implementing such integrated peer sessions. First of all, the implementation should be embedded and supported by all staff members in the department. Only then will residents feel safe enough to open up and use confrontations as an incentive to learning.

Second, we suggest making use of real/authentic confrontations or clinical situations brought forward by the participants themselves. This allows learning of communication to become integrated with the daily medical work context, and the learning process becomes learner-centered and experiential (what does this specific resident need at this moment in time to develop into a skilled communicator). Learner-centeredness is necessary to enable personalization and internalization of new behavior. In case a resident lacks specific confrontations to initiate his or her learning process, collecting feedback from real patients (or colleagues, or nurses) can be powerful because of its authenticity. Another suggestion is to install video cameras in one or more consulting rooms within the department to be able to make recordings of real patient consultations. These video recordings are another effective form of authentic material to be used as input during the peer sessions to enhance reflective practice.

A third implementation point is to avoid making these sessions compulsory. Learning through coercion does not work as effectively as learning through intrinsic motivation [13]. We have found that intrinsic motivation is unmistaken present amongst learners in all specialties we studied. A remark frequently made by our respondents was that the obligatory (and reductionist) character of their current training actually counteracted their intrinsic motivation, especially when enforced by poor role-models.

A fourth implementation point to consider is to have the peer sessions guided by an independent person who has experience in supervising communication and socio-emotional issues. A positive corollary to this solution is that such a person is not part of the hierarchical system and does not need to assess residents' general performance. This adds to the perceived safety of such peer sessions.

Another point of practical value rising from this thesis is to reconsider the use of behavioral checklists in the assessment of communication skills. When used in a strict way, these checklists are reductionist to the extent that they do not take proper account of the hidden aspects of communication and the context in which the communication occurs. We therefore suggest using these checklists not as a goal in itself, but only as a supporting tool to help assessors give words to behavioral aspects of the communication process they are assessing. On top of this, assessors should keep in mind the purpose of the consultation as well as the overall perceived feeling of usefulness of the communication within the consultation. In this way the non-visible aspects are better represented during the assessment.

A related issue of concern is the fact that when assessment is summative, then this is felt as thwarting the learning process. Passing the assessment then easily becomes a goal in itself rather than an instrument for skills improvement. Summative assessment fuels to display unauthentic communication behavior, only to pass the assessment. To

make doctors less skeptic about communication skills training and assessment, we suggest replacing summative assessment of communication skills by formative assessment focused on concrete feedback and driven by personal learning goals. Such type of formative assessment would better emphasize the supportive character which residents in our study preferred communication learning and assessment to be.

A final added value or issue of concern raised in this thesis is the proposition that the five phases possibly also apply to the acquisition of other CanMEDS competencies, such as professional behavior or collaboration [14]. If future research indeed shows that the learning process for the other CanMeds competencies resembles the learning process we found for communication, then this might have further implications for postgraduate continuous education.

In sum, this thesis offers evidence-based guidelines for a more promising approach to addressing postgraduate doctor patient communication. Whether the promises actually come true is a matter of large-scale implementation and more research. As yet we can be certain that the current approach does not work sufficiently. In two ways money is currently wasted: the current training of doctor-patient communication in health care practice does not lead to the desired effects and the effects of current poor doctor patient communication are very costly. For these reasons we cannot afford not to act!

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