A collaborative strategy to improve geriatric medical education

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Abstract

Introduction: age-related demographic change is not being matched by a growth in relevant undergraduate medical education, in particular communication skills pertinent to elderly patients. To address this, a workshop for medical students focusing on important communication skills techniques for interacting with patients with dementia was designed by clinicians from the Geriatric, General Practice and Psychiatry departments at the University of Oxford.

Methods: one hundred and forty-four first-year clinical students (Year 4 of the 6-year course; Year 2 of the 4-year graduate-entry course) attended the teaching. One hundred and twenty-nine students returned feedback forms with 104 forms matched for individual performance before and after the session. Feedback forms assessed student-perceived confidence in communicating with patients with dementia before and after the session using a 4-point Likert scale with corresponding numerical value (low (1), medium (2), high (3), very high (4)).

Results: using the Wilcoxon Signed-Rank Test on the 104 matched forms, student-perceived confidence was higher post-teaching intervention (median = 2.75) than pre-intervention (median = 1.50). This difference was statistically significant with large effect size, $Z = -8.47$, $P < 0.001$, $r = -0.59$. Free-text comments focused on non-verbal communication skills teaching, suggesting that these sessions were most beneficial for topics hardest to teach in lecture-based approaches.

Conclusion: the teaching aimed to promote patient-centred care and multidisciplinary collaborative practice, encourage student self-reflection and peer-assisted education and provide insight into the needs of patients with dementia. Student feedback indicated that these objectives had been met. This easily replicable teaching method provides a simple means of improving communication skills.

Keywords: geriatric, education, communication skills, medical student teaching, patient communication, dementia education, older people

Introduction

Despite elderly patients having unique communication needs, the proportion of time medical schools allocate to such teaching remains small, both in the UK [1, 2] and abroad [3]. A recent review by Tullo and co-workers [4] highlighted this discrepancy, partly attributing it to the slow pace of undergraduate medical curricula change, despite national plans emphasising the importance of geriatric medicine [5, 6]. Indeed, until this programme, there was no dedicated training in communication skills for patients with dementia and behaviours that challenge at Oxford University Medical School. Students had lectures on dementia and delirium and were exposed to patients with these conditions during clinical attachments, while communication skills teaching focused on more general issues, such as breaking bad news.

Communication skills teaching is difficult to deliver with lecture-based approaches [4]. Medical schools’ experiences [7, 8] suggest that students most appreciate interactive sessions with trained actors. Students thus learn from mistakes in a safe environment, receive individual feedback from clinicians and simulated patients and assess each other, learning how to give and receive constructive feedback.
Methods

The course was designed and delivered by a consultant geriatrician, psychogeriatricians and a general practitioner (communication skills lead for the medical school), bringing a broad range of communication experience to create scenarios mirroring common situations encountered by medical students and junior doctors when working with patients with dementia.

The first scenario focused on non-verbal skills: a foundation year 1 doctor (FY1) gaining consent for venepuncture from a patient with dementia who cannot communicate verbally. In the second scenario, an FY1 conducts a triadic interview with a patient with dementia and their assertive relative, trying to dominate the conversation. Previous communication skills teaching included interviews with non-English-speaking patients and translators but had not involved differing objectives of patients and relatives. Techniques to calm patients with severe dementia and behaviours that challenge were introduced in the third scenario, addressing distress in a patient without capacity to understand their need to be in hospital, as well as safety of a patient and attending clinician.

Four mornings of communication skills sessions were run during clinical attachments in 2014. Teaching lasted 2 h with up to 20 students divided into four groups with an actor and a facilitator being repeated that day with a new group of students. The facilitators also included trainee geriatricians and final-year medical students. Actors experienced in teaching communication skills and facilitators were given a 30-min introduction prior to the session.

After introduction to the ‘patient’, each student interacted with them in the above scenarios. The facilitator led a constructive feedback session based on basic skills (such as use of appropriate tone of voice, body language or eye contact) and higher level of discussion (such as reflection from the student group, actor and facilitator). Students then swapped to become the doctor, continuing the role play trying out different communication techniques in the situation [8]. The session focused on the process of communicating with such patients, not on the end result of the scenario [9].

After the sessions, each student was given written recommendations detailing various communication techniques for such situations (written by all authors), which is from this academic year incorporated in the medical school communication skills handbook.

Results

After the session, all students discussed their feelings and learning points with the whole group. Anonymous self-assessment was collected before and after the session to track changes in perceived confidence in communicating with patients with dementia. Confidence was assessed using a four-point Likert scale (low, moderate, high, very high) with each point assigned a numerical value from 1 (low) to 4 (very high). Eleven students completed forms by circling more than one Likert scale point, and confidence for these forms was therefore calculated as half between the two values indicated.

Of 144 students participating, 129 returned forms (89.6% response rate). 25/129 (19.3%) were discarded from the statistical analysis (but not the free-text comment analysis) as the before and after sections of the forms had been separated and were unable to be matched. Using the Wilcoxon Signed-Rank Test on the 104 matched forms, student confidence was higher post-intervention (median = 2.75) than pre-intervention (median = 1.50). This difference was statistically significant with large effect size, $Z = -8.47$, $P < 0.001$, $r = -0.59$. Figure 1 shows the number of students with each perceived confidence value before and after the session, including those students who circled more than one Likert scale point.

Of the 104 students, 90 (86.5%) had increased confidence, with 15 (14.4%) increasing their confidence by two or more Likert points. Twelve (11.5%) had unchanged confidence. Two students (1.9%) had reduced confidence after teaching, stating in the written feedback that they had underestimated their ability to handle challenging situations; ‘…we’ve lots to learn’.

All 129 feedback forms were assessed for free-text comment. 95/129 (73.6%) students most valued the non-verbal communication skills teaching (such as appropriate eye contact and body language). This project can be seen to provide an effective approach to non-verbal communication skills teaching, otherwise hard to deliver in traditional, lecture-based approaches [7].

Discussion

This workshop was developed to educate students to communicate effectively with both patients and carers of those
with dementia and behaviour that challenges, via various learning strategies: reflective practice [10], self-efficacy [11], self-directed learning [12] and peer-assisted education [13]. Students were encouraged to appreciate the importance of non-verbal communication skills and adopt appropriate communication strategies in difficult circumstances [14].

The sessions complied with Knowles’ seven principles of andragogy [15], a set of guidelines for adult educational practice. At the start of the session, students discussed their learning objectives, afterwards reflecting on whether these had been achieved. Written student learning objectives were very similar to those of the organisers and included statements such as ‘…how to deal with challenging situations involving dementia patients confidently and learn effective communication strategies …’ and ‘…to better understand the difficulties that may arise when communicating with patients with dementia …’.

Students observed each other and gave constructive feedback, developing their own teaching practice. Reflective practice was both in and on action [10]: students’ reported appreciating ‘…repeating the scenarios so we had a chance to implement what we had learnt …’ and during the session students discussed previous experiences proving that the feedback was formative [16]. Also, by promoting ethical practice, relationship-centred care and collegiality, parts of the hidden curriculum were addressed and possibly influenced [17, 18, 19]. Unplanned benefits of the teaching included final-year medical students informally discussing career options with trainees, thereby fostering interest in these specialties. Indeed, other studies have shown that improved gerontology education has also been associated with medical students looking more favourably upon future careers in the specialty [20].

The limitations of the statistical analysis were that not all students returned feedback form, and of those who did return, not all could be matched for student-perceived confidence before and after the session. The corresponding Kirkpatrick intervention level of impact of this teaching programme would be 2b: the acquisition of new knowledge and skills [21, 22]. Free-text comments showed students’ acquiring skills: including prioritising ‘addressing the patient’s own concerns’ and using ‘a variety of techniques to gain attention and consent’. Self-reported confidence largely increased during the session; however, until students are surveyed again following further clinical placements, behavioural change and other higher levels of the Kirkpatrick intervention scale cannot be assessed. (The authors are in the process of designing a further study to address these issues.)

Another limitation to this teaching is the cost. Four actors, each paid £25 per h, were needed for up to 20 students for the 2-h session: equating to £10 per student per session. This is, however, significantly cheaper than many other small-group, role play-based educational programmes, for example the Systematic Training in Acute Illness Recognition and Treatment for Surgery course costs £150 for one foundation trainee for 8 h [23].

Due to the overwhelmingly positive feedback, these teaching sessions have been timetabled for the coming year with the addition of a further scenario, the wandering patient.

Conclusion

Developing communication skills is difficult with traditional, lecture-based teaching; this project describes one means of learning and practising verbal and non-verbal communication techniques. Rehearsing with actors playing the roles of challenging patients allowed students to become more confident in these scenarios prior to clinical placements. This teaching did not adopt a one-size-fits-all approach. Each facilitator aided students in developing different ways of interacting with such patients. This teaching, based on sensitive communication and a person-centred approach, both known to be essential to good dementia care and central to professional development [2] is to our best knowledge a unique approach to dementia education.

Worldwide, the increasing prevalence of patients with dementia, often complicated by behaviour that challenges, necessitates such training, and this programme demonstrates a simple, easily implementable yet effective means of providing appropriate education of the future medical workforce, both in the UK and abroad. (The authors are grateful to Mrs E. Hawkes, mental health nurse, for advice given during the pilot project. Due to organisational issues, she could only start teaching on the course from this academic year and she is now a regular facilitator.)

Key points

- This paper describes a communication skills teaching workshop designed to address the lack of specific elderly care communication skills teaching in most undergraduate medical education programmes.
- The project was the result of interdisciplinary involvement from various hospital and community teams involved in elderly care: specialist nurses, geriatricians, psychiatrists and general practitioners.
- Feedback from the programme was very positive with students attending reporting a statistically significant increase in perceived confidence in communicating with patients with dementia and behaviours which challenge.
- The ability to practice communication skills with trained actors should help provide students with the necessary skills and confidence for hospital- and community-based encounters with such patients and their next of kin, improving the care these groups receive.

Conflicts of interest

None declared.
References


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