REVIEW

Teaching and learning consultation skills for paediatric practice

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Effective consultations with patients and their families are important for patient satisfaction, adherence to treatment, and recovery from illness. Communication problems among health professionals are common. Fortunately, the skills of effective communication can be taught and learned. This paper highlights evidence based approaches to teaching these skills with minimal resources.

Medical certifying bodies worldwide stress the importance of good communication skills.[1–4] With good reason: consultations between doctors and patients are central to professional practice. Patients rate good communication with their doctor as important as clinical and technical competence.[5–7]

WHY SHOULD WE TRY TO IMPROVE OUR CONSULTATIONS WITH PATIENTS AND THEIR FAMILIES?

Effective communication can increase diagnostic accuracy, improve patient understanding and information retention, enhance patient satisfaction, increase adherence to treatment, and improve health outcomes.[8–21] Despite this, the commonest mistakes reported to the Health Service Ombudsman are ones of communication.[22] This also seems to be a problem in paediatric practice; the Health Commission's Young Patient Survey of 2004 showed that many children were unhappy with the way healthcare professionals in hospital related to them.[23]

However, we can improve our own and our trainees' skills; with the right type of training, improvements can last for years.[24–26] This paper reviews essential elements of effective communication teaching and learning, so that the reader can develop a realistic approach to training in any department. We augment research evidence and best practice with practical tips on setting up teaching sessions, giving effective feedback, and using educational materials.

WHAT CONSTITUTES EFFECTIVE COMMUNICATION?

To improve our own consultations and help each other learn, we must define what makes interactions between doctors and patients effective. This may not come easily; we are unlikely to have received comprehensive training in this discipline as undergraduates.[27] The medical educational literature contains many consultation ''frameworks'' that can be used for teaching and learning.[28–31] These usually encompass a combination of evidence based *behaviours/skills* (for example, displays eye contact, uses predominantly open questions) and *tasks/outcomes* (for example, achieves a shared management plan).[30] Box 1 outlines a skeleton for the consultation, onto which specific behaviours and skills can be pinned.

A framework for teaching and assessing communication with adolescents has recently been published,[32] but no other frameworks specific to paediatric consultations exist. We are currently addressing this with development of a novel assessment tool, designed to encompass behaviours and skills thought to be important components of paediatric consultations[33] In the meantime, ''adult'' frameworks can be used to teach effective communication in paediatric consultations: interactions in triadic consultations follow a format parallel to dyadic ones and employ similar communication skills.

Experiential learning

In the same way that acquiring other advanced skills such as skiing necessitates practice, analysis, and rehearsal, so do consultation skills. Experiential learning—learning by doing—has a greater impact on communication behaviour than any other teaching/learning style. Didactic teaching is ineffective (merely knowing what skills to use does not change behaviour), and role models per se do not enable students to acquire enhanced skills of communication.[34–39] We propose four essential features of experiential communication skills learning (box 2).

Small group or one-to-one teaching

Each participant should have time for observation, and feedback, with or without practise. We recommend between four and eight learners for group work. You may find running interactive groups daunting: these sessions tend to be more variable than lectures, demanding flexibility in leadership style and interaction with individuals of different personalities and learning needs. You may need to simultaneously operate audiovisual equipment, manage role plays, and manage group feedback. Fortunately most clinical teachers, with brief training, have the potential to be effective teachers of communication skills.[40 41]

Observation

Observation of one's performance is essential for behaviour change. This implies self-observation if you are to improve your own skills, and observation of your trainees if you plan to teach them to communicate more effectively. Observation necessitates live scrutiny, review of recorded consultations, or role play. We favour

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Box 1: Essential elements of the consultation (adapted from the Kalamazoo consensus statement)[31]

- Building the doctor–patient relationship
- Opening the discussion
- Gathering information
- Understanding the patient's perspective
- Sharing information
- Reaching agreement on problems and plans
- Closure

the latter two methods (see *Practice/rehearsal of skills* for discussion about role play). Although being video recorded can add to the anxiety that learners feel when being observed and commented on, video/audio playback has greater impact on communication behaviour than live observation or individualised feedback alone.[36 42 43] Recordings of consultations enable you to see/hear exactly what is said and done, and what effect this has on families. We recommend videotape recordings, as these enable feedback on non-verbal exchanges as well as verbal ones. Feedback plus review of video recorded interviews result in greater changes to behaviour than feedback on audiotaped interviews (see box 3).[36]

Detailed, individualised feedback

Experiential learning is potentially hazardous, as it exposes learners to constructive criticism. This must be handled carefully. Observe the basic rules about feedback set out in box 4.[45–49]

There are a number of methods for executing feedback; one of these is widely known as ''Pendleton's Rules''.[50] In summary, a learning activity occurs → the learner is invited to comment on ''what went well'' → the rest of group is asked suggest anything else that ''went well'' → the learner is invited to suggest ''anything that could be done better'' → the group is asked to add to this. The positive elements can be reiterated/built on at the end (the ''feedback sandwich'').[45] While Pendleton's rules promote self-assessment, follow safety precautions such as ''positive first'' and make recommendations for improvement rather than criticisms, the artificial segregation of ''good'' and ''could do better'' points necessitate judgement about what was seen, which can promote a defensive climate.[47]

What alternative methods overcome the tendency for feedback to be judgmental? Agenda led outcome based analysis (ALOBA) focuses feedback instead on the learner's stated learning needs or agenda.[51] In summary: the feedback process starts before the activity by discovering and recording the learner's agenda → activity → self-assessment by learner according to stated agenda → group is invited to add ideas → range of suggestions of ways to improve created → learner selects from range what they would like to try next time. This method of learner centred feedback is motivating because it focuses on the learner's needs.[46]

Box 2: Essential characteristics of experiential learning about consultation skills

- Small group/one-to-one learning
- Observation
- Detailed, individualised feedback
- Practice/rehearsal of skills

Box 3: Practical tips for making video recordings

Equipment needed
- Video camera(s), extra microphones, connectors for TV playback, tripod(s)
- TV and VHS recorder (if recording onto VHS format)

Equipment set-up
- Make sure your viewfinder enables you to capture everyone's body language
- Use a desktop microphone to maximise speech quality
- Scrutinise consultations for sound and picture quality before teaching; poor quality can sabotage feedback sessions

Consent
- Explain who will see the video, purpose of recording, how long you will keep it
- Obtain written consent from parent(s) and/or child
- Obtain separate written consent for examination if you wish to record this
- Obtain consent again at end of consultation in case family's views have changed

Storage
- Ensure any video material and copies are locked away

See the GMC website for further guidelines on making recordings[44]

Practice/rehearsal of skills

Communication skills require practice. This should occur in an environment that enables the learner to make mistakes and try different communication strategies, where the ''patient'' suffers no adverse consequences. The use of actors as simulated patients creates a safe environment for rehearsing new skills, and is widely used in medical curricula.[52–54] It is now incorporated into paediatric training programmes in number of deaneries, and although it involves a recurring cost, is relatively cheap per trainee. Actors have specific advantages over participants role playing patients, and real patients themselves: they can reliably reproduce roles (enabling learners to see how others cope with identical situations), can be trained to portray difficult roles (anger, crying, cultural issues), and can provide feedback from patients' viewpoints. In Anglia we teach communication skills to postgraduates using a problem based approach: learners bring contemporary ward or outpatient based ''communication problems'' to training sessions. With the help of actors we develop these problems into impromptu role plays with which the trainees rehearse and experiment. This heightens motivation and offers trainees the potential to immediately apply what they have learned to real life.[55]

USING PRE-RECORDED VIDEO MATERIAL TO TEACH AND LEARN COMMUNICATION SKILLS

The observation and rehearsal/experimental opportunities that role plays using actors provide means that they remain the ''gold standard'' of consultation skills training. In some areas, access to simulated patients may be limited (cost,

Box 4: Fundamental principles of effective feedback

- Orient the learner(s) to the purpose and structure of the feedback
- Give feedback as soon as possible after a learning activity (for example, watching a video)
- Self-assessment by the learner first
- Only involve peers in giving feedback with the explicit consent of the learner
- Be behaviour specific—what you *saw*, not your judgement of it
- Be concise
- Balance reinforcing statements with corrective ones
- Agree an action plan for future learning

access to actors, training), and video material more widely available for training. In this section, we shall cover the practicalities of: (1) setting up a training session; (2) making effective use of pre-recorded video material; (3) using frameworks to evaluate the behaviours you see; (4) giving feedback; and (5) closing the session. Finally we shall discuss running a programme of sessions.

Setting up a training session

You can use a video recording of a real consultation in a one-to-one setting with the clinician involved, or with a small group. If the latter, make sure the clinician in the video gives consent for its use for training, and determine that what is seen and discussed within the teaching session is confidential.

Before you watch any video, ask the clinician involved what he/she would like feedback about. Learners new to the practice of identifying areas of feedback not infrequently reply with, ''let's just get on with looking at it and then see''. One of the solutions to this is to consider the goals of communication (see box 5).

The learner's agenda will help you decide how much of the video to watch. Brief your group to analyse the video, focusing specifically on the areas requiring feedback. This is important, lest your group's feedback becomes ill defined and evaluative.

Making effective use of pre-recorded video material

You can either watch and comment on the whole of a consultation, or stop and evaluate it in short clips. Watching a whole consultation takes longer, as you may want to return to the video a second time to teach specific points. If you are short of time, stop and start the interview as you go along. Keep the time display on throughout, and brief the group to log the times of the observed behaviours. You can then return to these points in time should you wish to make teaching points.

Using frameworks to evaluate the behaviours you see

Whichever framework/checklist you use to teach communication skills, give a copy to each group member before watching a video. Use these as checklists for self/peer assessment and as a template for feedback.

Giving feedback

Once the video has been watched, check again with the clinician on the tape what behaviour they require feedback about. Invite this person to make a self-assessment first, then involve the group (with the consent of the clinician), and finally yourself, in giving feedback. You need to manage the group carefully to keep it focused on the learner's prior stated agenda. Finally, agree an action plan for future learning.

Box 5: Goals of communication in health care (adapted from Kurtz *et al*[56])

- Increasing diagnostic accuracy
- Increasing efficiency
- Increasing supportiveness
- Enhancing patient satisfaction and health outcomes
- Promoting collaboration and partnership

Closing the session

In the same way that closure is important to doctor–patient interactions, so it is with teaching interactions. Recap the main learning points from the session. Generalise from specifics to principles, making sense of the session for all participants.

Multiple sessions

Research of consultation skills teaching has consistently shown that one-off sessions do little to change communication behaviour.[57 58] Learning has to occur repeatedly to reinforce effective behaviours and to build on what has already been learned.

RUNNING TRAINING IN YOUR OWN DEPARTMENT

The expansive and compelling research evidence linking effective communication with patient benefits aside, there are other stimuli for postgraduate training in consultation skills. Trainees with substantial communication training as undergraduates have promoted extension of this training into the postgraduate arena. The introduction of communication stations into the Membership (MRCPCH) and Diploma (DCH) examinations run by the Royal College of Paediatrics and Child Health has led to candidates' requests for coaching in consultation skills. Despite these incentives, ever increasing demands on clinicians' time are likely to generate resistance to setting up novel communication skills training sessions at a departmental level.

How can we make the best use of limited time to promote good communication in our departments? Structured teaching sessions, say, scheduled for three or six monthly intervals within a departmental teaching programme should focus on: (1) the skills of interviewing; (2) the skills of giving information and planning treatment, generally not taught in detail at undergraduate level; and (3) dealing with specific issues such as breaking bad news or communicating about adverse events. You can begin to teach the skills of (1) and (2) by discussing the problems of (3) with your trainees; such a problem based approach is likely to maximise interest and learning. If you cannot devote time for structured learning in groups, find out what individual trainees find difficult about doctor–patient interactions, watch one or two consultations in clinic, and focus on a couple of consultation skills at a time. There is no doubt that teacher/faculty development and a well structured curriculum of communication skills are important, but effective learning can occur even when supported by minimally trained teachers.[41] We overlook the learning opportunities that even the inexperienced and short handed of us possess to the detriment of our trainees and patients.

SUMMARY

Consultation skills are important and can be taught and learned. Using video recorded material in combination with

individualised feedback in small groups has the greatest impact on communication behaviour. This paper summarises the evidence for effective, feasible ways to teach in the postgraduate setting. However, while we all possess the potential to help our trainees to communicate better, we can enhance this by developing our own communication and teaching skills. Training to teach essential communication skills need not be extensive, but it should include training in experiential teaching and learning for maximal benefit to trainees.[40] We strongly recommend that clinicians enthusiastic about teaching consultation skills attend a relevant staff development programme, which may be available at a local medical school, university or deanery, or nationally (such as those run by the Medical Interview Teaching Association).[59]

More information and resources about faculty development programmes and all other topics mentioned in this paper are available via the corresponding author.

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