“it really felt real”

The Introduction of Simulated Patients to the Communication Skills Course for Third Year Medical Students at the University of Melbourne

Dr. Kathryn Robertson
M.B.,B.S. (Melb.), FRACGP

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Declaration of originality

This thesis contains no material which has been accepted for any other degree in any university. To the best of my knowledge and belief, this thesis contains no material previously published or written by any other person, except where due reference is given in the text.

Signature: 

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Abstract

Communication skills are essential to the practice of medicine, and are now included in most medical curricula. Training in communication skills requires an experiential approach to teaching and assessment that focuses on mastery of performance. Simulated patients were introduced to the Communication Skills course for third year medical students at The University of Melbourne in 1995. This thesis describes the evaluation from the first two years of their use, and is set within the body of literature regarding this innovative educational method.

The fundamental research question was: Did the introduction of simulated patients represent an improvement and enrichment in the teaching of communication skills to third year medical students? A qualitative evaluation was undertaken by focus groups with students, tutors and simulated patients, and by student questionnaire.

The evaluation supported the use of simulated patients in the teaching and assessment of the Communication Skills course and showed that the innovation led to:

- increased verisimilitude of role-play interviews
- ethical and educational process advantages over alternative experiential methods
- a better match between learning objectives and teaching / assessment methods
- improved Faculty control over case content and standards for performance
• an increase in students’ awareness of the importance and range of communication skills in medical practice

• the introduction of a range of new learning opportunities such as observation between peers, feedback from (simulated) patients and rehearsal of specific skills.

The evaluation found that simulated patients provide an effective and powerful method of teaching and assessing process skills for medical students. The findings also suggested some modifications to the current course: for example increased student exposure to simulated patients, and greater integration of communication skills development throughout and beyond the undergraduate medical curriculum. Finally, the research led to developments in other uses of simulated patients within medical education.
Introduction

The General Practice Unit of the Department of Public Health and Community Medicine (restructured as the Department of General Practice and Public Health in 1998) has been responsible for a course in Communication Skills for Third Year Medical Students at the University of Melbourne since 1989. The course involves a series of tutorials in second semester, just prior to the students commencing the three year clinical component of their undergraduate training.

The course has evolved through a number of formats over the years, but has invariably taken an experiential approach whereby students practise the theoretical basis of effective communication by role play and videotaped interactions with each other. Originally, assessment was by videotaped interview between two students, with the interviewee in a role-play of their own devising. This assessment process was fraught with difficulties, including the possibility of collusion between the students, unrealistic case portrayal, lack of standardization and the students not approaching the task seriously.

In 1995 a grant was awarded to the Unit to establish and trial the use of simulated patients in the communication skills course, through an innovative teaching incentives program, under the auspices of the Faculty of Medicine.

This thesis outlines the introduction of simulated patients to the Communication Skills course for third year medical students, including qualitative evaluation
from the first two years experience. The first chapter sets the background for the
thesis by establishing the predominant themes in the literature concerning
communication skills in medical practice: their fundamental importance;
common problems in doctor-patient communication; and the identification and
teaching of effective skills. This is followed by an overview of the history of the
use of simulated patients in medical education since their introduction in 1962.

The second chapter entitled “Issues in the use of simulated patients” draws on the
body of literature in the area to address the educational advantages and
disadvantages of simulated patients, including a brief comparison with alternative
experiential methods. The properties of reliability, validity and realism are also
established, and the effect on the medical curriculum explored.

The introduction of simulated patients to the third year medicine Communication
Skills course at the University of Melbourne is described in chapter three,
including a course description and an outline of the recruitment and training of a
pool of actors.

The process of evaluation by focus groups and student questionnaire is detailed
in the fourth chapter, followed by an analysis of the results. Five focus groups
were held in the first year: two with tutors, two with simulated patients and one
with students. In the second year, two focus groups were held with tutors, and a
questionnaire was distributed to all third year students, which included a specific
question on the use of simulated patients.
The dissertation is concerned with whether the introduction of simulated patients represented an improvement and enrichment in the teaching of communication skills. This is indicated by the following:

- increased verisimilitude of role-play interviews
- ethical and educational process advantages over alternative experiential methods
- a better match between learning objectives and teaching / assessment methods
- improved Faculty control over case content and standards for performance
- an increase in students’ awareness of the importance and range of communication skills in medical practice
- the introduction of a range of new learning opportunities such as observation between peers, feedback from (simulated) patients and rehearsal of specific skills.

The evaluation findings led to modifications in the Communication Skills course, as well as developments in the use of simulated patients in other areas of medical education, including both undergraduate and postgraduate training. These developments are outlined in Chapter 5, while further potentials for the use of simulated patients in medical education are explored in Chapter 6. The dissertation is concluded in Chapter 7, followed by an extensive set of appendices, that provide further detail on the use and evaluation of simulated patient in the third year medicine Communication Skills course at the University of Melbourne.
The first issue that needs to be considered is whether the *process* of clinical performance, including communication skills, should and can be taught and assessed.
Chapter 1: Background

Communication skills in medical practice

Communication skills in the medical consultation have been defined as: “the interaction between doctors and patients (that) involves the forming of a relationship and the gathering and giving of information...to promote the physical, social and emotional well-being of patients and their families” (Canadian Medical Association cited in [1]). In the medical context they are also sometimes referred to as interviewing skills, and are the essential foundation of good consulting or clinical skills. Kurtz et al include communication skills with knowledge, problem solving and physical examination as the four essential, inextricably linked components of clinical competence. While they assert that communication is not simply a personality trait, but a series of learned skills, they also acknowledge that communication is closely linked to self-concept, self-esteem and personality [2].

Basic necessities of medical practice

A movement to improve the training and evaluation of doctors' communication has been gathering momentum at an international level since the late 1970s, from professional medical bodies, academics, and patients themselves, [2-8]. In fact, research has suggested that patients are more concerned about their doctor’s communication skills than their medical or technical competence [3]. The recommendations arising from the 1993 World Summit on Medical Education included the following: “Adequate communication skills...are basic necessities of
clinical work” [1]. A survey reported in 1979 showed that 84.7% of medical students themselves believed that interpersonal training courses were “absolutely necessary” as part of their training [3]. This is supported by later papers showing that medical students perceive communication skills as critical to the practice of medicine [4, 6].

**Problems in doctor-patient communication**

Numerous studies have demonstrated substantial problems in doctor-patient communication [4, 9-12]. Traditionally, the teaching of medical students to consult with patients has focussed on the taking of a medical history, and the lists of questions purported to elucidate the different symptoms which relate to dysfunction in the various body systems [13, 18]. Thus, medical students practise asking a check-list of closed questions. This doctor-centred approach as formally taught and reinforced by role-modelling, often does not allow the patient to voice their concerns or even raise their main problems. The implied premise for a check-list approach is that by remaining in control, the doctor can efficiently and effectively define the patient’s problem. However research has demonstrated quite the reverse - by prematurely focussing on the initial concern, and applying a narrow medical approach, doctors often miss important cues and information that would make their diagnosis and management significantly more accurate and patient-centred [2, 5-6, 8-9, 11, 13]. An effective history-taking phase of the consultation alone will produce the information required to make a diagnosis in greater than 75% of consultations [19]. Good communication skills are also required to reliably pass information from physician to patient and are essential to
the quality of the doctor-patient relationship [2, 9, 17, 19]. However, discord between the doctor and patient regarding the nature, significance and appropriate management of the patient's problems leads to confusion, dissatisfaction, poor compliance and outcome [2, 4-6, 9-11, 17-18]. Poor communication is frequently cited as the single most important factor leading to medico-legal action [2, 5-6, 8, 15, 18]. Doctor satisfaction, patient satisfaction, a reduction in medico-legal action, improved health outcomes, and patient loyalty to the doctor all depend on effective communication skills [2, 4-6, 8-11, 14-15, 17-19].

Identified skills

The choice of communication skills to include in the medical curriculum is based on twenty-five years of research which has identified which skills are essential and effective in overcoming the above problems in clinical practice. These skills underlie "patient-centredness" and include encouraging the patient to tell his / her own story through the use of specific questioning styles; active listening; reflecting and attending skills such as silence, re-statement and summarization; negotiation; responding to emotion; attention to verbal and non-verbal cues; building rapport and demonstrating empathy. One of the fundamental characteristics of a patient-centred approach is an understanding that different communication styles are needed for different patients, with different problems, at different times. The patient-centred clinician is flexible and responsive to the individual patient. [2, 4-7, 9-11, 19-24]. As well as introducing students to specific skills, training programs have an important influence on the students
attitudes, particularly towards the value of exploring the patient’s perception of their problems [5, 9, 20].

**Effective communication can be taught**

Research has also shown that these skills can be taught, leading to an increase in knowledge, awareness, confidence and a change in learners’ behaviours, although there has been conflicting evidence as to what extent these changes are retained [2, 4, 6-8, 10, 11, 16-19, 25-28]. At the very least, specific teaching may prevent the decline in medical students’ communication skills that has been demonstrated as they progress through training [4, 6, 10, 25]. As doctors become relatively fixed in their clinical style soon after graduation, it is important that the patient-centred skills that have been proven effective are taught at the undergraduate level [29]. It has also been demonstrated that the patients of clinicians who have been trained in communication skills to be more patient-centred, have “greater satisfaction, fewer somatic symptoms, less social dysfunction, less depression and anxiety, and reduced functional disability” i.e. greater measurable physical and psychological well-being [2, 18, 19, 30]. However, as Pritchett and Frude made clear in their early work, the teaching of skills does not require the adoption by the learners of a conformity of style [31]. For example, different levels of emotional involvement may represent equally effective and skilled consultations. The aim is to help students develop their own effective style, based on a sound understanding of communication skills theory.
Educational Processes

As the content of a communications skills course has been developed, attention has turned to the teaching process, based on adult learning principles and research into the specific effectiveness of different programs [2, 13, 17, 19, 28, 31]. The importance of practice over theory has been emphasised [28], as has the need to develop learners’ self-awareness in a communication skills training program [19]. Kurtz et al proposed that experiential teaching of core communication skills leads to a conversion of “understanding, knowledge and attitudes into behaviour and action” [2]. However, Roche et al warn of the importance of matching the form of educational input to the stage of learning [29]. They suggest that didactic approaches may be more appropriate to convey knowledge at earlier stages of training, complemented by experientially interactive approaches later in training. A suggested ideal would be short focussed programs on aspects of communication developed and modelled through the entire undergraduate medical training and beyond [8].

An innovation in education

Competence versus performance

The movement way from the traditional means of educating and assessing medical students which only focuses on medical knowledge and competence, rather than actual clinical performance, demanded innovative methods of teaching, evaluation and research [14, 32-39]. Clinical performance had usually been inferred from secondary outcomes, e.g. review of case notes or student case presentations [40], which tend to summarise medical content, rather than reflect
the process of how such data was obtained and integrated. While students may have sufficient knowledge of performance processes, and even recognise their importance, they often lack the skills to apply this knowledge in practice. They have also been shown to be poor in judging their own ability to communicate effectively [4, 41]. Miller suggested that students must progress through several critical steps in developing the behaviours required of the professional [42]. The foundation is knowledge, but they must also know how to use that knowledge - which he correlates with competence. But beyond this, the student must perform appropriately and demonstrate how the knowledge is used (performance). He defines the peak skill as "independent action". Teaching and assessment methods must link theory (knowledge) with performance. However, studies have suggested that medical students are rarely observed interviewing or examining a patient during their clinical training [2, 34, 43]. The use of simulated patients provides an opportunity for students to learn and be assessed on their clinical performance directly, providing comprehensive and accurate information on the upper levels of Miller's hierarchy. They are thus a more reliable method of focussing on the skills and behavioural process of clinical practice, than methods of assessment which measure the candidates ability to memorise and reproduce medical facts in an exam situation [1, 44].

There is often a discrepancy between a student's performance as measured by an assessment using standardized patients and their performance by other assessment methods. This has been attributed to the gap between competence and performance, and that such assessments are measuring something different
from traditional knowledge-based examinations [45-48]. This is not to suggest that knowledge of content and process skills are not interconnected. One cannot perform well without a solid basis of knowledge, but one can be very knowledgeable, but not be able to apply this knowledge in practice [1, 41]. The teaching and assessing of medical students needs to be a balanced reflection of the range of cognitive, behavioural and attitudinal attributes required by the medical professional.

**The value of simulation in education.**

Simulation is useful for teaching and assessing complex psychomotor skills, when the use of the real setting is inappropriate, for example because of impracticality, risk or expense. Simulation has been used in industry and business for many years for a wide variety of training situations, the most obvious example being the training of aircraft pilots. Simulation allows the very complex skills that need to be mastered by pilots to be broken down to their component steps, learned, rehearsed and evaluated under controlled conditions. The instructor can create specific scenarios to teach specific skills; add complexity according to the student’s progress and assess the student’s ability to integrate all the knowledge, skills and attitudes required to perform the task to the standard required of the professional. Simulation increases the effectiveness and efficiency of learning complex or high risk skills [33, 49]. Flying a plane is high risk - not to be learned through real life trial and error. It is important that the pilot has experienced and mastered a range of situations or problems, some of
which would be impossible to produce at will in the traditional learning setting.

The same is true for medical students and doctors.

**Simulated patients**

Simulated patients are non-physicians specifically trained to present as real patients to medical students or doctors for teaching, assessment or research purposes. They are usually professional or amateur actors or members of the community without formal acting background, but with the interest and ability to be trained. They are a subgroup of the umbrella term “standardized patient”, which also includes actual patients who are trained to present their own illnesses repeatedly in a consistent way [50]. They have been used across the spectrum of medical education, with undergraduate medical students, vocational trainees and practicing physicians. They are most effectively used in the teaching and evaluation of the interactive aspects of the consultation: communication and interpersonal skills, interviewing, physical examination and patient education [43, 44]. They provide an opportunity for “learning from the human encounter” [51]. Students interact with simulated patients as though they were real patients. Depending on the objectives of the educational session, they may undertake a complete or partial consultation with the simulated patient, which might include physical examination. The simulated patient usually provides some evaluation of the interaction, most often by completing check-lists documenting the behaviours of the student [46, 52]. They may also be involved in giving feedback directly to the student.
The use of simulated patients has been shown to be a reliable, valid and powerful educational and assessment tool, accepted and regarded favourably by both medical educators and students [43, 47, 50, 53]. This thesis will outline the evidence for this from the significant body of educational research, and from the author’s experiences of the introduction of simulated patients into the medical course of the University of Melbourne.

The development of simulated patients as an educational tool

The use of standardized patients since their inception as an educational tool in 1962 has been varied, and evolved to meet different teaching, assessment and research objectives. They were initially used by Howard Barrows for the demonstration of the components of physical examination, specifically the examination of the neurological system, while he was the Director of the neurological service and residency program of the Los Angeles County Hospital [33]. He worked closely with Stephen Abrahamson, renowned medical educator and director of the USC Division of Research in Medical Education, to develop and evaluate the teaching technique. In the face of considerable resistance from the medical establishment, Barrows persisted in using simulated patients because, as he said, “I was learning things about those students I would never have found otherwise”, particularly about students’ interpersonal, clinical and reasoning skills [50]. The feedback Barrows was able to provide to his students about their skills was powerful, the students were enthusiastic about the method and Barrows was confident that it was effective [50, 51].
Barrows further developed the simulated patient’s role in teaching, particularly in problem-based, experiential learning - learning by doing and receiving immediate feedback. Barrow strongly believed that “the student should be given an opportunity to learn in the same manner as the student is going to practice” [51].

Paediatrician Paula Stillman started using simulated patients to teach and evaluate basic clinical skills in the early 1970s in her position as paediatric clerkship director at the University of Arizona. She developed a behaviourally-based rating scale to enable to simulated patients to evaluate the students interviewing skills for teaching, feedback and assessment purposes [34, 51, 54]. She later developed patient instructors - real patients who are trained in how they should be assessed on history and physical examination on the basis of their own illness, and then themselves take on the task of teaching and evaluating the physical examination undertaken by the medical students [50].

Standardized patients have been used most extensively in summative assessment programs, and there is now a solid research base on the psychometric properties of reliability and validity of their use in performance-based examinations, particularly when the standardized patient is themselves undertaking the assessment. Particularly instrumental in establishing the legitimacy of standardized patients have been Jerry Colliver and Mark Swartz; Cees van der Vleuten and David B. Swanson; Geoffrey Norman; Nu Viet Vu and Howard Barrows himself [35, 42, 46, 49, 51, 52, 55-60].
As well as individuals striving to establish standardized patients as a credible education methodology for teaching and assessment, there have been a number of key, influential organisations whose support has been important for the establishment of this technique - particularly in the United States. These have included the Liaison Committee on Medical Education (LCME) of the American Medical Association, the National Board of Medical Examiners (NBME) and the Educational Council for Foreign Medical Graduates (ECFMG). The dissemination of the use of standardized patients was boosted by a conference held in June 1984 entitled “How to Begin Reforming the Medical Curriculum” co-sponsored by the Southern Illinois University School of Medicine and the Josiah Macy, Jr. Foundation [51]. Because standardized patients provided a method of teaching and assessing process, the methodology became instrumental in a push towards more performance based medical curricula. The Association of American Medical Colleges (AAMC) 1984 report Physicians for the Twenty-First Century: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine (the GPEP Report) recommended that faculties should develop procedures and adopt explicit criteria for the systematic evaluation of students’ clinical performance [61]. When the Group on Educational Affairs sponsored by the AAMC conducted a survey in 1989 of 142 curriculum deans of US and Canadian medical schools, 94 (70%) of the 136 responding schools indicated that standardized patients were being used in a variety of ways. These included the teaching and evaluation of interviewing skills; medical history taking skills; patient education and counselling; complete
or specific physical examination skills, especially breast, pelvic and male
genitourinary examination including rectal examination [62]. By comparison, in
Britain in 1991 the use of standardized patients was rare [6]. In 1991 the LCME
included in its accreditation standards a requirement that medical schools
“develop a system of assessment which assures that students have acquired and
can demonstrate on direct observation the core clinical skills and behaviours
needed in subsequent medical training.” [42, 51].

In December 1992 the AAMC held a Consensus Conference on “The use of
Standardized Patients in the Teaching and Evaluation of Clinical Skills”, which
produced an analysis of the status of the use of standardized patients to that point
in time. This included a consensus of the conference participants on the
appropriate and effective uses of standardized patients and a collective
assessment that the psychometric characteristics of standardized patient use in
assessment were “reassuring” [40, 44, 52]. A repeat of the 1989 survey in 1993
of 142 curriculum deans of US and Canadian medical schools showed that 111
(80%) of the 138 schools responding use standardized patients in teaching and
assessment - an increase from 70% [63]. Standardized patients were variably
used as simulators, evaluators and teachers. In 1997 plans began to use
standardized patients in licensure and certification testing in America [46],
although the College of Family Physicians of Canada had been using
standardized patients in its certification examination from as early as 1969 [64].
The use of standardized patients has spread from the United States around the world. Particularly active in incorporating and developing their use have been medical schools in Canada, the United Kingdom, Australia, The Netherlands, Norway, Switzerland and Spain [1, 6, 12, 17, 20, 29, 35, 39, 47, 51, 65-70].

Paula Stillman developed a collaborative project with three Chinese medical schools and the China Medical Board of New York, Inc. to develop a competency-based clinical skills teaching and assessment program in China using simulated patients in 1997 [28]. This included identifying cultural issues in transplanting such an educational approach, and making modifications as appropriate. Similar culturally specific programs have been developed in Israel, Russia, The Ukraine and Brazil, with support from the ECFMG [51].
Chapter 2: Issues in the use of simulated patients

Educational process issues

Availability

A very pragmatic benefit of using simulated patients is their availability. A major problem of clinical training that is based on students gaining experience on the patients in their teaching hospital is that the Faculty has limited control over the experiences that students have [33, 34, 43, 49, 50]. An appropriate, consenting real patient is unlikely to be available for teaching purposes at precisely the right time and place to meet the educational objectives. Clinical training is therefore constrained by the characteristics of the patients who happen to be in the wards or out-patient clinics of the teaching hospital at the time. Particularly with the trend towards day surgery and shortened hospital stays, combined with the increasing super-specialisation of the tertiary hospitals, medical students exposure to patients can be fairly random, biased and narrow. The majority of doctor-patient interactions occur outside the large tertiary hospitals where students traditionally undertake the majority of their training. By using simulated patients, course coordinators can ensure the students' clinical experience is more representative, equivalent, appropriate to their learning needs and provided at the time and place that is conducive for learning [2, 29, 40, 50, 62, 71].

This is not to say that simulated patients are useful only as a substitute when real patients are not available for teaching purposes. The different approaches to
experiential learning, such as contact with real patients, role-play and the use of
simulators, each offer specific advantages and disadvantages depending on the
learning objectives, and their use should be determined by those aims. Simulated
and standardized patients have many unique characteristics that offer educational
opportunities unmatched by any other method.

Reducing the risk to real patients

By using simulated patients, students can gain experience and practice without
putting at risk the health and welfare of real patients, who are already vulnerable
by the very nature of their illness. As most teaching of medical students occurs
in large, tertiary referral hospitals, the real patients on which medical students
develop and hone their skills are often the sickest and the most vulnerable.
Alternatively the medical students may be exposed only to those patients whom it
is felt will not suffer too much at the hands of the neophyte - which further limits
the range of their clinical experience. Patients in an emergency situation, or with
complex presentations, or a strong emotional component tend to be excluded.
Medical students therefore learn on the "safe" patients and may never develop
their skills for working with patients in more challenging circumstances [33].

While medical students need contact with real patient to learn their profession,
the patients are not there for the purpose of the student’s education. Patients
must provide consent to be interviewed or examined by medical students, but it
must be asked how valid that consent is when patients are approached by their
treating medical attendants on whom they are so dependent for their care. And
when the teaching of medical students is included in large ward rounds, there is often not even the formality of patient consent. A course on doctor-patient communication, which espouses the importance of exploring and incorporating the patients needs, rights and agenda can be in danger of modelling the exact opposite values if it uses patients as "educational material" in a manner which is dehumanising, disrespectful and not mindful of the dignity of the patient. Conversely, a communications skills course offers an opportunity to create an environment and expectation for a patient-centred approach not just when students graduate as doctors, but in their interactions with the patients from whom they learn as undergraduates.

**A transition from theory to real patients**

In some cases, simulated patients can be used as a transitional stage, before students are "let loose" on real patients - like training wheels on the first bicycle. Communication skills are explicitly taught because it is clear that students are not adept at interviewing. While they are developing their skills, they will therefore be awkward, clumsy and sometimes inappropriate. By practising with simulated patients, they will then be more accomplished and less anxious when they begin to interview real patients, and will thus be in a position to gain more from this experience [33, 40, 50, 71, 72].

Simulated patients can provide a rich opportunity for the student to be confronted with the complexity of real patients - their fears, beliefs, emotional responses, life histories and stresses, coping mechanisms, family backgrounds, expectations,
attitudes towards their illness and the medical profession [51]. All of these factors influence the interaction, and may be explicit or covert, but most are highly sensitive. Students need to appreciate the importance of these issues, and to do this they must be able to explore them with the patient. The use of simulated patients allows them to experiment, learn and practise the skills to do so, in a safe, protected environment, which nonetheless approximates reality as closely as possible [2, 6, 19, 31, 50]. Jenkins in particular stresses this issue of relative safety for the learner [14]. He suggests that because the situation is not a real consultation the student and the patient can both drop their “defences with safety and share their frailties, their vulnerabilities, their fears and inadequacies, (and) the sense of warmth towards another human being”. This can have a profound impact on the student, and their appreciation of the power of their relationships with patients.

Several studies have in fact suggested that students not only learn as effectively with simulated patients compared to real patients, but may even rate higher in areas such as specific interviewing skills, patient satisfaction, student confidence and student satisfaction with the course [49, Simek-Downing, 1986 #71]. On the other hand, students may focus on different aspects of the consultation, such as psychosocial content, when they are interviewing real patients [21]. Simek-Downing et al have therefore suggested an integrated, step-wise approach in which students learn their basic interviewing skills in the relatively safe environment with a simulated patient. Once they have mastered these skills, they are introduced to real patients in the clinical context [21].
Custom-made cases

A major advantage of using simulated patients is that medical educators can select and expose the students to the exact case characteristics that are appropriate to the desired educational outcome and student’s level of learning. Problems can be chosen which emphasis parts of the curriculum, or which would be difficult or too sensitive to explore with real patients and thus which students may be unlikely otherwise to encounter [2, 9, 33, 34, 45, 50, 66, 72]. Course coordinators can determine the content, domain, emphasis and complexity of the cases to match their objectives [40]. The use of simulated patients can intensify learning which normally occurs piece-meal over a long period of time. Simulated patients enable students to practise communication skills with so-called “difficult” patients, and in the sort of emotionally charged situations that frequently confront doctors [40]. By using simulated patients, assessment can also be directly linked to the learning objectives.

Standardized, yet responsive

The umbrella term “standardized” was eventually adopted by leaders in the field, as this was regarded as perhaps the single most useful and unique characteristic of this innovative educational tool, particularly as the emphasis on the use of standardized patients in summative assessment and research in clinical performance increased. The term was initially used by Canadian psychometrician Geoffrey Norman in the early 1980s. A standardized patient can be presented to different students repeatedly, allowing for comparison between
the students' ability to consult with essentially the same patient, without the
variables that influence real patients. This has obvious advantages in assessment
and research, enabling standards to be set and comparisons made.

 Appropriately for such a significant attribute, much of the literature addresses the
issue of whether it is possible to truly achieve standardization and reproducibility
of roles, both with one simulated patient presenting the same case many times, or
with different actors portraying the same patient. Tamblyn (a trained nurse who
was originally recruited as a simulated patient and later became a trainer and
program co-ordinator in her own right) suggests that three parameters of
standardisation need to be considered [68].

1. Did the standardized patient present the same information to every
interviewer?

This does not mean that the exactly the same content must be delivered by the
patient regardless of the approach taken and the dynamics of the consultation. In
fact, one of the key features of the SP is that although they have been trained to
present the patient in a standardized manner, they are still responsive to the
individual interviewer. However, they must be consistent in the information that
they disclose and the manner in which it is offered. It has been demonstrated that
standardized patients can achieve more than 90% accuracy in portraying a case,
and that using multiple standardized patients for the same case has minimal or no
effect on reliability [12, 39, 45, 52, 69, 73].
2. Was the information provided under equivalent circumstances?

For example, if certain sensitive information is only to be offered when the
patient feels sufficient trust and rapport with the doctor, would all simulated
patients judge this equally? This requires a subjective assessment of the doctor-
patient relationship and is therefore more difficult to standardize, but this can be
achieved with focussed training [69].

Simulated patients can be trained to be standardized for presentation to the
doctor, and guided as to how they will respond to certain approaches. But a
consultation is a dynamic process, and from the moment of its commencement
each consultation is unique, and the doctor and patient will respond to each other
as well as deal with the content. Thus any attempt to standardize the
presentations should focus not just on the medical content (which is relatively
easy to “get right”), but on the more complex issues of patient agenda,
personality and communication style, including non-verbal communication;
feelings; reactions; strengths and weaknesses and context.

3. Were other issues introduced by the simulated patients that were not part of
the original case?

These may be issues raised in the history, or arising from the physical
characteristics of the actor. For example, in the author’s experience, a doctor
who was interviewing a very fair skinned simulated patient incorporated an
assessment and advice regarding prevention of sun damage and the detection of
skin cancers. As well as creating a deviation from the original case (as was being
portrayed by other actors in other locations simultaneously), this situation was very confronting for the simulated patient involved whose own person was abruptly brought into the role they were playing, thus blurring the boundaries that actors will necessarily draw between themselves and the character they are portraying to allow them to be objective.

The above questions are concerned with standardization of patient presentation. To this could be added a fourth question:

4. *Can standardization be achieved in the evaluation of the consultation, either with one simulated patient presenting the same case many times, or with different actors portraying the same patient?*

It has been shown that standardized patients can be trained to accurately recall and interpret what occurred in a consultation, using comprehensive check-lists after the consultation. This is true for both content and process skills such as interviewing, communication and interpersonal relations [56, 57]. The more specific and behaviourally orientated the items on the check-list, the more accurate the evaluation by the standardized patients [47]. However, standardized patients can also evaluate more subjective qualities such as empathy as demonstrated in a study by Colliver *et al* in 1998 [59].

**Reliability**

The issue of reliability, which refers to whether measurements obtained with a particular method are reproducible (i.e. consistent and stable) with repeated applications of the process, has been extensively researched and documented [35,
46, 52, 56-58]. The reliability of pass / fail decisions is high and better than that for quantitative examination scores. The reliability increases with increased numbers of cases. For quantitative assessment, seven to thirteen cases per student are required to reach acceptable reliability, but for pass / fail decisions only two cases are needed. [44, 46, 47, 52, 57]. The consensus view of the AAMC conference was that: “Reliability is less important in applications to teach and judge beginning competence (e.g. an introduction to clinical medicine course) and provide formative assessment that reinforces education. However, the normal psychometric guide-lines for reliability probably apply when a student’s academic progress or graduation is to be decided.” [44].

Validity

The other psychometric parameter which is important to consider is validity, which refers to whether an examination actually measures what it purports to measure - in this case, competency of clinical performance [35, 46, 58]. The difficulty is that there is really no “gold standard” for measuring clinical competence against which to compare the use of standardized patients - in fact, that is why they were originally developed. In reviewing the literature, one also needs to be clear whether any validity measures cited refer to the use of simulated patients in “role-play” consultations (i.e. Is a student’s interaction with a standardized patient a true indication of their interaction with a real patient?) or the validity of simulated patients’ assessment of students’ performance (Are simulated patients able to accurately and correctly identify the construct that is being tested for, e.g. communication skills?).
Thus, many of the papers compare simulated patients’ ratings of student performance with those of Faculty-physician observers [46, 52, 57], which is concerned with the latter question. In relation to the former question, Yelland stated that “Standardized patients offer greater face validity and a more direct measure of clinical performance than indirect measures...” [70] This is supported by the consensus view from the AAMC Conference [40]. Sanson-Fisher and Poole reported that the level of interpersonal skills displayed by medical students with simulated patients is no different than those used with real patients [74]. This was corroborated by Norman and Tugwell (cited in [55]). In contrast, Pieters et al. found that when the interview was conducted with a simulated patient compared with real patients in the practice setting, competency in communication skills, patient-centredness and psychosocial approach was greater, but lower in interpersonal skills [65]. This may actually be related to changes in the setting and context of the interview, rather than the validity of simulated patients per se. To further consider this aspect of validity, it is appropriate to explore the issue of realism.

**Realism**

As stated above, for the use of simulated patents to be regarded as valid, it has to be shown that the consultation undertaken with the simulated patient is the same as if the patient were real. Kinnersley and Pill [39] proposed that the ultimate test of this is whether candidates can identify simulated patients in a blind trial. There have been numerous studies that show that simulated patients are
indistinguishable and are therefore presumably treated the same way as real patients [12, 46, 49, 55, 57, 66, 74, 75]. Not only medical students, but practicing physicians, professors and educators who have consulted with simulated patients have rated them as realistic, and are rapidly drawn into the verisimilitude of the interaction, even when doubts have been expressed initially [6, 20, 23, 33, 45, 76]. The participants at the 1992 AAMC Conference concluded that: “The use of standardized patients gives a high-fidelity, credible and realistic assessment technique that assures that students’ skills are observed and measures actual performance.” [40]

**Alternative experiential methods**

While there are difficulties in the use of simulated patients, and they can only ever be an approximation to reality, there are also issues to be considered in the use of alternatives for the teaching of interpersonal skills to medical students.

**Students role-playing patients**

The process of students interacting in role play as patients is used extensively in the teaching of communication skills, including at Melbourne University. It incurs no extra costs and the students are immediately on-hand in tutorials to take on the role-play. The most educational gains are usually made by the student role-playing the patient, who gets a valuable insight into the patient’s perspective of the consultation [50].
However, it is often difficult for students to fully adopt and portray the patient role realistically and in any depth. Thus it is hard to achieve the verisimilitude required for the process to be a powerful learning experience for the student role-playing the doctor. Frequently, the student-as-patient is overly helpful to his colleague, or conversely, overly obstructive and not responsive to the skills used. The students have a social relationship which intrudes into the role play scenario. Students have not been trained as simulators, nor to give detailed feedback, and care must be taken to assist them to discard a role after the role-play. There is also often a problem with the students approaching the role-play seriously, both in the role of patient or doctor, when they are consulting with their peers.

Real patients

Apart from the issues of availability, ethical concerns, patient safety and student comfort outlined above, there are other potential pitfalls in the use of real patients to teach process skills to students. Although a real patient's reactions will be authentic and credible, they are affected by every consultation. Patients become practiced in presenting their history with every re-telling. Their stories are modified by the responses of the interviewer, and they quickly learn what symptoms are taken seriously, and which are passed over. It is a commonly recognised phenomenon that when a patient first presents to a primary care provider such as their general practitioner, their story is relatively disorganised, and replete with a whole range of detail the doctor must sift through. It could be argued that this untainted history reflects more of the patient's agenda, and their fears, expectations and concerns. With each re-telling the story becomes more
medicalised, and more pitched to the doctor’s perceived agenda. The end result of this can be the highly medicalised patient who presents with a diagnosis, rather than a story of their experiences.

Because real patients are affected by every consultation, enlisting them to help in the training of medical students will also impact on their own medical care. During the interactions with students, they will have had issues raised, perhaps clumsily, that they will take on to their future consultations with their own doctor. Also, if their own doctor has recruited them for the teaching of medical students, the patients may sometimes expect special treatment or a favour in return.

**Learning Issues**

**Standardized, yet responsive**

As stated above, this is one of the most important characteristics in the use of this powerful educational tool. By using standardized patients, the "same patient" can be seen by all students or doctors in the program. As well as the obvious advantages in course design, this is also a major advantage in teaching as students can observe how their colleagues approached exactly the same consultation, and how the outcomes can vary significantly depending on the direction taken and the skills used by the interviewer [2, 72]. This is one of the
most powerful confirmations of the importance and impact of communication skills on the consultation.

Feedback

Standardized patients have been trained to provide written and oral feedback to students [11, 26-28, 38, 39, 45, 62, 63, 72]. Adult education principles support the use of expert feedback and practice to effect changes [29]. Following well-accepted principles this feedback should be immediate, descriptive, relevant, specific and constructive. Most often the simulators have been trained to complete a check-list of demonstrated behaviours, which has been validated to represent a gold standard against which to judge the student’s performance [27, 28, 32, 34, 35, 56, 62]. Thus the focus is on the student’s performance, rather than the patient’s reaction. The standardized patient is, in a sense, acting as a proxy for Faculty - they can be trained to represent the expertise of the profession and, as such, have been shown to be as effective as Faculty in effecting behavioural changes in students’ interviewing skills, and may be more effective in developing students’ empathic skills [27].

Alternatively, feedback from the simulated patient can be based on a unique, enriching perspective - that of a genuine patient - that is otherwise rarely available to students or Faculty [2, 6, 14, 20, 35, 40, 62, 70, 71]. This feedback process may be facilitated by a member of the teaching staff [17, 26]. Exploration of the patient’s perspective is a key factor in alerting students to their own influence on the patient’s presentation [76]. The simulator can be an
objective patient advocate, accurately representing the patient’s view, without risking their own relationship with their health care providers [14, 76]. However, they are more skilled than real patients in reflecting on the consultation in an analytical manner and articulating how the consultation felt to the patient, the impact of specific communication approaches and their perceptions of the interviewers’ attitudes. They can be more sensitive than any external observer - including the teaching staff - to subtle nuances in the verbal and non-verbal tone of the interview [20]. Learners have been shown to appreciate and improve from this immediate, relevant feedback of videotaped interviews [26, 77].

Influence on the curriculum

In 1984, the Josiah Macy, Jr. Foundation in the United States held a conference entitled “How to Begin Reforming the Medical School Curriculum”. The conclusion of the conference was that the most effective way to influence medical education would be to change the assessment systems to include methods of assessing clinical reasoning and performance, specifically through the use of standardized patients [50]. Because the assessment of process skills had previously been based on very poor secondary evidence, which would not have met any psychometric criteria, this crucial area of clinical practice had usually been neglected in assessment, which very powerfully gave students the message that it was not of value. To quote George Miller: “While a curriculum defines what will be taught, it is the evaluation that dictates what must be learned. That is the message that most forcefully goes to students as a clear reflection of Faculty values” [42]. The innovative techniques that were developed to meet the
increased attention to the teaching and assessment of the process of medical practice in themselves further emphasise the importance of these processes. The 1992 AAMC Conference concluded that the use of standardized patients “focuses students’ attention on their performance as practitioners, motivates them and encourages active learning” [40].

An educational tool which opens up the possibility of effective teaching and assessment of interpersonal skills requires time and attention within an already crowded curriculum. Priorities have to be reassessed, and educational objectives re-defined [44]. Many medical schools have responded by restructuring their teaching and assessment practices to reflect the importance of communication and interview skills [15, 28, 33, 47, 78].

To formally teach and evaluate communication skills, Faculty must reach a consensus and define what “good communication skills” actually are. These concepts are then tested and further refined by their use with simulated patients. The inclusion of the patient’s perspective into the teaching of medical students thus impacts not only on the students themselves, but on the teaching staff whose focus, awareness and understanding of the dynamics of the doctor-patient interaction is enhanced [20, 33, 35, 43, 48, 50, 76]. The involvement of simulated patients in the curriculum can challenge the medical paradigm. Because simulated patients are available, standardized and reliable, performance can be analysed, compared, and used to develop specific behavioural criteria. It
has also been suggested that feedback can be obtained about teaching effectiveness by observing students with standardized patients [33, 48, 72, 79].

**Barriers**

The introduction of standardized patients has certainly not been smooth or universally embraced. There are many issues to contend with in setting up such a program in a medical school, not the least of which is gaining support from the Faculty itself. When Barrows and Abrahamson first started publishing articles on the use of standardized patients (then called programmed patients) they were regarded as undermining the dignity of medical education. The USC dean received complaints from medical schools across America after the publication of their first paper [51]. There was scepticism regarding the believability of the simulation, and therefore whether students would accept them as a valid educational tool. The most effective way of convincing the sceptics was to invite them to consult directly with a simulated patient. Barrows created many supporters by this simple approach.

Other concerns regarding the psychometric parameters of reliability, reproducibility and validity of the technique have been answered by the sound body of research undertaken over thirty years as described elsewhere in this dissertation.

Teaching and assessment programs using simulated patients tend to be more complex and of longer duration than traditional methods [29, 46]. It could be
argued that this is because traditional methods are "short-cutting" and simply overlooking the process aspects of consulting. It may be that the underlying question is not whether simulated patients are "worth it", but whether observation of actual performance for teaching and assessment purposes is recognised as valuable.

The first step towards change is dissatisfaction with the current approach. The early proponents of the use of standardized patients were dissatisfied with the methods of teaching and assessment available at the time. Simulated patients have to be perceived to satisfy a need within the curriculum - and that need and resultant change may be largely patient driven for an improvement in the communication skills of medical practitioners.

Issues still creating barriers to the adoption of this educational tool are the feasibility and cost of using standardized patients on a large scale [2, 29, 62, 77, 80]. The testing time and cost need to be considered in the overall context of medical education [46]. While the establishment costs - both financial and in terms of Faculty time - of recruitment and training and setting up the administration of a simulated patients program can be significant, the ongoing costs are considerably less. Once a pool of trained patients is established they can be used again and again and are able to take on a new case quite quickly. Time spent by medical educators scouring hospital admission lists, obtaining consent from and screening new patients as suitable for educational purposes is usually greater than that required to organise a trained simulated patient to attend
a tutorial [40]. Administrative staff can take on that organising role. One way to decrease the establishment costs is to establish collaborative arrangements between medical schools and teaching hospitals, as is the case with the Morchand consortium of eight New York medical schools, and the Macy Foundation in association with the American National Board of Medical Examiners [40, 51, 52]. However, Faculty boards do need to be firmly convinced that the increased funding required is justified by significant improvements in teaching, assessment, and ultimately outcome - their graduates' competence and performance.

The cost of using simulated patients often requires that they be used sparingly. This, however, is not necessarily a drawback, if it then means that consideration is given to the particular educational advantages of using simulated patients over other methods, and that they are therefore used selectively and with a defined and appropriate purpose. They will then retain a powerful influence on the training of medical students which would be lost if they were used indiscriminately or so frequently that students became blase. Some of their power rests in their uniqueness.
Chapter 3: The simulated patient program for the Communication Skills course at the University of Melbourne

Course Description

The Communication Skills Course at the University of Melbourne consists of an introductory lecture and 9 weekly tutorials in groups of 12 students, covering such areas as: Introduction to Communication Skills (Listening and Responding Skills I and II; Influences and Interactions in Communication; Communication across Differences); Breaking the Taboos (Communication with patients when discussing sexual issues; Communicating bad news; Receiving bad news - the patients perspective; Death and dying) and Taking a Social History. During the period of evaluation, the tutors were academic general practitioners, psychiatrists or psychologists, although this pool has since been expanded to include medical practitioners from a broader range of medical specialities. The course includes pre-reading which provides the theoretical basis of the skills which are then explored and practised in the tutorials, using specific role-play exercises. In the last tutorial, a simulated patient is introduced to the students, who then practise integrating the skills to take a contextual history from the patient in role, with feedback from the tutor, the simulated patient and their peers. A combination of educational strategies such as written handouts which systematically define the essential skills; active small-group tutorials; rehearsal; observation; specific feedback and video review, is supported in the literature as an effective approach to training in behavioural skills [2, 6, 13, 14, 25, 29, 77]. Acquisition of
communication skills theory is improved by the analysis and discussion of content followed by the “hands-on” experience of interviewing and peer feedback with a facilitator [41, 77]. This experiential learning approach fits with Piaget’s theory that learning only occurs when the learner creates or recreates for themselves (cited in [2]).

Assessment

Assessment is both formative and a “hurdle” requirement. The tutors attend a training workshop to clarify standards for “pass” and “repeat” interviews. The workshop also provides the tutors with training on giving feedback, and they are given a written reinforcement of the principles of learner-centred feedback (Appendix 1). The videotaping / assessment sessions are spread over three weeks, with a subgroup of 4 students from each tutorial group presenting each week for a 3 hour session. During the first hour, the students are each allocated 15 minutes to record an individual, video-taped interview with a simulated patient, taking a contextual history. Only the student and simulated patient are in the room during the interview, although administrative staff are available to start the video recording, and ensure a smooth transition between students. The simulated patient is different from the one introduced to those particular students during the last tutorial, to avoid confusion regarding the patient role, or the simulated patient having preconceived ideas about the student based on their “practice run” which could interfere with the interview. Each of the four students interviews the same patient, beginning the interview / relationship from the same point. The scenario is that the medical student is presenting as themself, as a
third year student on a clinical rotation to general practice. The general practitioner has asked permission from the patient to be interviewed alone by a medical student prior to their appointment with the doctor. The medical student will take a social history from the patient, with specific reference to the impact of the patient’s context on their current situation and presentation to the doctor. This is quite different from most other assessments of medical students in which the student is required to respond as though they were already a doctor, which requires a certain amount of projection and acting in a situation which is still hypothetical. The assessment of the Communication Skills course is based on the students actual current performance and the skills level expected at their stage of training.

After each student has recorded an interview, the four students, their tutor and the simulated patient convene for feedback / assessment. The format, objectives and ground rules for the session are established. The first student introduces their video to the group, discussing which areas in which they felt they did particularly well, and which they felt they could have improved upon. This provides a focus for the group to view the video, which they then proceed to do. The student who is showing their video holds the control, and is encouraged to stop the video at any point to discuss what is occurring in the interview, or how they were feeling. Any other members of the group, including the simulated patient, can also request the video be stopped to discuss or clarify any issues that might arise. The tutor acts as facilitator, and in practice frequently takes the lead in identifying keys points in the interview valuable for analysis. The interviewer is usually
invited to make the first comment, usually in response to an open question from the tutor such as: “How do you feel the interview is going so far?” The tutor facilitates a discussion, drawing on feedback from the simulated patient, and, in reality, using the very communication skills that are the subject of the course. The students consider particular strengths in their communication skills, areas of difficulty, and what they would do differently in retrospect. The feedback needs to be selective - there are usually many more teaching points that the tutor identifies than could be effectively covered in a single session - it is better to leave the student with a few well-defined areas to consider and develop, rather than overwhelm them with too many issues. The focus is on the process of the interview - the communication skills and their effect, the feelings, reactions and internal reasoning of the participants, and the exploration of alternative approaches as appropriate. It is possible, and powerful, to resume the interview with the simulated patient at any point, and try out any new approaches - learners can rehearse and experiment. The simulated patient reacts appropriately to the different approaches and can provide immediate feedback on their effect.

At the end of the video, the tutor summarises the main points of the feedback - both specific strengths and identified learning objectives. The videotape remains the property of the student for further self-evaluation or future reference. The same process of video feedback is then repeated for all students. Rather than this viewing of each others’ interviews being repetitive, there are usually many learning opportunities in addressing the different approaches each student has taken, and the resulting difference in the direction and tone of the interview.
Interestingly, in a similar program, it was reported that interviewers initially tended to focus on the similarities between their interviews, while the patient's feedback highlighted the differences [76] - this is also true of the University of Melbourne course. Thus the students are able to learn from each other by observing how each of them approached the same patient in the same circumstance. This is one of the most powerful learning experiences of the exercise, along with the specific feedback from the simulated patient.

This small group session using simulated patients and immediate, constructive feedback based on video-taped interviews allows the student to learn naturally from their own observation of their performance and utilises the principles of adult learning which have been shown to enhance and increase enjoyment in the acquisition of skills [2, 24, 26]. The consensus from the 1992 AAMC conference was that the most useful application for simulated patients is for teaching and formative assessment in courses such as this one on basic interviewing skills [40]. Some authors have stressed that the timing of the use of simulated patients is important, as this is perceived to be a high risk activity by the students, and is therefore better placed towards the end of the course when the students have developed a working knowledge of the communication skills and have developed a level of group trust essential for honest analysis and feedback [14, 29]. The analysis of the video-taped interview is not dissimilar to a technique called stimulated recall devised by the psychologist Norman Kagen, and further developed by Art Elstein and Lee Shulman at Michigan State University [41, 50, 51]. This technique involves the video-taping and immediate review of a doctor-
patient interview, stopping and starting the tape and getting the doctor to reflect on his/her thoughts, feelings and reasoning at key points in the encounter.

The students’ videos are marked as either “pass” or “repeat” by the tutor. Although not based on a numerical score, the tutors are given a guide for this summative assessment (Appendix 2). The students who are required to repeat their assessment re-convene approximately two weeks later, and the above process is repeated in groups of four, with one of the course leaders acting a tutor / assessor. The student is matched with a different simulated patient, a different tutor and a new case written especially for the repeat assessment to avoid violations of test security. This is more for student perception as it has been shown that although students do receive information about the examination from other students, those in the groups tested later do no better or worse than those tested earlier. This is particularly true when interview process skills are being assessed rather than medical content. [52, 57, 79].

This assessment process matches the principles outlined by the co-ordinators of the Clinical and Communication Skills course at Monash University [24]. They developed the following criteria:

1. Assessment should be **formal**, so that its significance is evident to students.

2. Assessment should be **educational** - providing feedback - and **remedial** - with failing students being counselled and then allowed to repeat the assessment until progress is satisfactory.
3. **Development** of skills and **insight** regarding skills should be considered together with the absolute level of skills, particularly for students whose first language is not English.

4. Students should take an **active** part in the assessment - and that participation must form an integral part of the assessment.

The assessment of the Communication Skills course blurs the traditional dichotomy between teaching and evaluation. It is simultaneously a pass / repeat summative assessment hurdle, and a powerful learning opportunity through self-evaluation, and feedback from a tutor, peers and the simulated patient. In the AAMC 1992 Conference Summary, George Miller challenged the traditional dichotomous concept and suggested not only that teaching and evaluation are part of a continuum, but that evaluation is the single most powerful teaching tool available [42]. Certainly, what and how we choose to evaluate gives a conspicuous message to the students as to the priorities and values of the course.

**Recruitment**

Initial recruitments for simulated patients at the University of Melbourne were made through local amateur theatre groups. As with other professions, there is quite a strong network among actors and "word of mouth" soon spread amongst the acting fraternity. Interviews were conducted by three of the senior teaching staff for the Communication Skills course, including the author, who had also had previous experience working with simulated patients in the vocational training program for the Royal Australian College of General Practitioners. The
task of the simulated patient is complex - the successful simulator must be able to fully immerse themselves in the role, reproduce key features of the history accurately but still respond to the interviewer, while simultaneously monitoring their own reaction so as to be able to use this as the basis for feedback. Therefore, criteria for acceptance for training as a simulated patient were acting ability, including the ability to memorise, improvise and express emotions both verbally and non-verbally, and a basic ability to observe and recall the process of a consultation while participating in it. For this reason the interview included a brief role-play. Simulators must also be able to divest themselves of the role and the emotions generated by the interview at the end of the session. Occasionally the Faculty staff will be required to debrief the actor, particularly if the interview has been especially emotionally charged.

The applicants' backgrounds were reviewed and motivation for involvement was also screened for, in an attempt to exclude applicants with a particular personal agenda or negative attitudes towards the medical profession which would interfere with the educational process. Applicants must have a genuine interest in helping to train doctors. While not taking a personal medical history, applicants were advised that they should make the co-ordinators aware of any particular circumstances which would affect their portrayal of any cases. For example, the author once gave a simulated patient a case history to portray of a woman presenting with a threatened miscarriage in the early stages of pregnancy. The simulated patient requested an alternative case as she was herself two months pregnant (although she had not yet announced this).
As far as possible, an attempt was made to identify those applicants who would not have the emotional or physical stamina required by the roles. Screening is important for the protection of the applicant as well as the course [2]. Training simulated patients is a large investment of time and resources, and so attempts were made to ensure that successful applicants will be reasonably available and reliable (e.g., organised, prepared and punctual), and not transient. The program, job requirements and pay were discussed. Howard Barrows, Paula Stillman, Kurtz et al and others have described similar selection processes [2, 28, 33, 54, 71] and they were also reflected in the Proceedings of the AAMC conference in 1993 [79]. Seventeen of the original applicants were invited to participate in the training workshop. Of these 10 were used in the first year program.

While it has been suggested that previous acting experience is one of the main factors determining accuracy of presentation [41], the author’s experience is not completely in accord with this. Barrows himself reported that the main criteria for selection should be motivation and a flair for acting, rather than formal acting experience and training [33]. While it is certainly true that very experienced and professionally trained actors generally are very effective as simulated patients, applicants without a formal acting background can also be very suitable. Interestingly, in the author’s experience, many teachers are attracted to the position, and fall into the latter group. In fact, one program using simulated patients in Norway, specifically and successfully recruited from among primary school teachers [66]. It is the author’s experience that the group that is most
problematic is those applicants with some acting training and experience, which has made them acutely conscious of the acting process. Thus they often present falsely because they are clearly acting a role, and are unable to convey a genuineness in their portrayal. There has even been an example of an actor practising different accents during their interactions! Quite often the underlying motivation of these applicants is to further develop their acting skills (or to network with other actors) and that is where their focus lies, whereas this is not an issue for the already skilled and experienced actor or those with no acting aspirations outside the program.

It can be challenging to develop a pool of simulators with a broad age range and ethnic background that is reflective of the wider community. Work is now underway to increase the diversity in the current pool of actors.

**Simulated patients’ reasons for becoming involved**

Actors are excited and challenged by the uniqueness of this experience, and feel it affords them an opportunity to develop their profession - particularly improvisational skills. This is not a problem as long as the actor’s agenda to practise their skills doesn’t take precedence over or interfere with the educational process, as outlined above. As the cases are based on real patients, and give an intimate insight into a patient’s world view and the doctor-patient relationship, becoming a simulated patient offers an opportunity to actors to explore an aspect of the human condition and to portray a variety of characters and problems. Once the acting community becomes aware of the program, there is usually no problem
recruiting sufficient numbers of keen, highly motivated and skilled applicants. The issue really becomes one of screening and selection.

A common motivation for involvement for both professional actors and lay people is ultimately altruism - the desire to help students become the best doctors they can be.

Case Development

The cases are chosen for their content and representativeness and are loosely based on real patients, or composites of patients, with not only identifying features, but unwanted complexities modified to meet the educational objectives. It is sometimes useful to be able to assure students of this basis in reality - they are sometimes surprised at the range of issues, seemingly unconnected to their medical problems, that patients discuss with their doctors. This again reinforces the need for doctors to be skilled communicators in a wide range of interactions with their patients. The medical content of the interview is kept very simple and as a relatively minor feature in the patient's presentation to the doctor, so that the focus remains on the communication skills, and not on the student's medical knowledge - which is often quite rudimentary at this level of their course. The course co-ordinators have also learned from experience to provide the case with a broad social context covering a range of issues for the patient, rather than one major psychosocial problem which tended to encourage the students to approach the interview as a "fishing expedition" in which the aim is only to uncover "the
problem". The case must reflect the course’s focus on process rather than content.

The case is then prepared along the same lines as that suggested by Barrows [33]: details of the presenting issue including onset, duration, severity, interference with daily living etc. Important positive findings in the patient’s context are included such as family and social details, occupation, interests and so on. The simulated patients are advised that anything that is not specified should be answered in the negative or in such a way as to deflect further exploration of the area. The simulated patients are not given formal scripts - instead they are provided with in-depth descriptions of the patient at the time of presentation.

The patient’s demeanour and mood as well as underlying concerns are also detailed. They are given guidance as to what information they will readily impart and that for which they will have to feel a strong rapport or empathy with the doctor to disclose.

Some authors have described elaborate processes to develop the cases, involving large committees of physicians from a range of specialities, including academic and primary care settings, providing collaborative input, and extensive pre-testing prior to a case being accepted for use [23]. The author’s experience is reflected in the comments by Paula Stillman [54], who stated that writing a case is not very complex, particularly if a recipe is followed. Thus she reported that if she discussed a potential case with a Faculty member who was the original patient’s
treated doctor, after a half an hour she would have enough information to produce a fairly acceptable case. It partly depends on the purpose for the case. If the program is for quantitative assessment, and the role is to be played by different simulated patients with a high degree of standardization, validity and reliability, then much work needs to be done to define the parameters of the presentation. If, however, the program is primarily for teaching or pass/fail assessment, and which allows the individual actor to personalise the case to some extent, without interfering with the educational objectives (as with the Communications Skills course at the University of Melbourne), then the case description does not need to be so rigidly defined.

Each simulated patient is given two cases over the assessment period of the three weeks. This is more to maintain the freshness and enthusiasm of the simulated patients for the role play, rather than for any concern regarding test security. As well as role playing each case four times a week, the simulated patients participate in a detailed analysis of the communication skills of each student in the feedback session, and through this process can become over-rehearsed and lose their essential "patientness" (see below).

**Training**

The training of simulated patients run by the Communication Skills course co-ordinators involved several key steps most of which are common to the training programs referred to in the literature \[2, 14, 20, 23, 27, 33, 49, 54, 62, 66, 69, 73, 75, 77, 81, 82\]. Training times of 1-14 hours per case have been reported in the
literature, depending on the complexity of the case itself and any additional training required for assessment or feedback [49, 54, 62, 63, 66, 71]. Barrows himself reported that a new simulated patient can be trained to accurately portray a case in two to three hours, and that most of the training time quoted in the literature actually related to training the actors to complete the long assessment check-lists or to act as patient instructors [50]. Yelland suggested it took 10 hours of academic time to develop the case outlines, the marking guide-lines and to train the simulated patients [69]. It is important to note, however, that cases can be reused, and that an experienced simulated patient requires only very brief training to take on new cases. After the initial recruitment interview (which actually overlaps with training in some aspects), the training workshop held for the Communication Skills course runs for 3 1/2 hours, of which 2 hours is spent in case rehearsal.

The case outline

Simulated or standardized patients are given the case outline some time before the training session to enable them to prepare the role, ready for refinement at the session. This also gives them the opportunity to highlight any issues for which they need further clarification.

Orientation

The simulated patients need to know some details of the course of which they will be a part. They need to understand the objectives of the course, the standards expected of the students and the structural details of the session. This
information was presented verbally during the training workshop in the first year, and developed as a written guide for simulated patients for the communication skills course by the second year. (Appendix 3)

The simulated patient's responsibility

As the simulated patients are sometimes also involved in other courses, it is important to re-confirm their responsibility in the communication skills course, particularly that they will be required to give direct feedback to the students, and to define their educational relationship with the tutor.

Presentation of a model of providing feedback

A model of providing feedback is presented which is learner-centred, and is a modification of the model given to the tutors (Appendix 1). To help the simulated patients reflect on the interview, and to provide a focus and structure to their feedback, they are provided with a list of trigger questions (see Appendix 3).

Unlike other programs in which the simulated patient provides comments and perhaps suggestions on the specific skills demonstrated by the student, thus acting as teachers and evaluators [2, 28, 83], in this course the simulator gives feedback in role only about the individual patient’s feelings and reactions. These are areas that only the patient participant can accurately judge. They are thus required to provide subjective feedback from the patient’s point of view, rather than an objective comment as to whether a particular component of the history-
taking or physical examination was performed according to a check-list. The simulated patients are regarded as experts on the patient’s perspective of the consultation. They are not expert on medical interviewing and communication skills. The tutor acts as facilitator to provide feedback about the specific skills of the medical student. Thus the simulated patient is encouraged to frame their comments accordingly: “As (the patient’s name), I felt.....”. This is a powerful way of reinforcing the theory of communication skills, by providing the students with a patient response that has not been over-theorised. If the simulated patient has been trained to take on the role as instructor of communication skills their responses would appear less genuine and more constructed to match the theory they are espousing. As Barrows says: “It is so important not to do anything that makes him (sic) lose the quality of “patientness”” [33].

Demonstration

In the second (and subsequent) years, a demonstration role-play of an interview with a medical students has been shown to reinforce the structure and process of the education session.

Rehearsal of the role

The simulated patients are trained in groups of three or four who are all portraying the same role. Thus each simulated patient is trained by both playing the case themselves and receiving immediate feedback, and by direct observation of other actors portraying the same role, with ensuing discussion. The trainers are selected from the Communication Skills tutors and are thus fully conversant
with the course and the contribution required of the simulated patients. They train the simulators to accurately depict the patient’s behaviours. The trainers role play the part of students with varying abilities and approaches. The simulated patient is thus trained to respond to different behaviours while remaining consistent to the case. The simulated patient must be coached to avoid the temptation to help the students by volunteering information or dropping cues inappropriately. The trainer provides direct feedback, and the group also discusses any issues that arise through the role-plays. This process is similar to that involving the students.

The simulated patients also practise giving feedback based on the model presented earlier in the session.

**Plenary session**

The large group is reformed and any difficulties, insights or points of clarification which arose in the small groups are dealt with. A summary of the process is provided.

**On-going training and review**

Because the trainers are drawn from the pool of tutors, they are able to provide on-going support and feedback for the simulated patents. To this end, any inexperienced simulated patients, or those who it is felt need particular support, are paired with the tutors who are trainers. Occasionally simulated patents require remedial training, or even discontinuance, although this is a rare occurrence.
Chapter 4: Evaluation

The fundamental research question was: Did the introduction of simulated patients represent an improvement and enrichment in the teaching of communication skills to third year medical students? Evaluation using qualitative methods is presented for the first two years of the course involving simulated patients.

Evaluation Method

Objectives

The evaluation was specifically concerned with the introduction of simulated patients to an already established course, rather than the course overall. In-depth information was initially sought on the attitudes, opinions and experiences of the participants – the students, the tutors and the simulated patients themselves. The resultant data would be used to identify major themes in the use of simulated patients in the introductory teaching of communication skills, to support or refute the use of simulated patients outright, or suggest modifications to their use.

Why Focus Groups?

Krueger defines a focus group as a qualitative approach to gathering data through “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment” [84]. Focus groups are an appropriate method for an exploratory evaluation, which is concerned with complex reactions. They provide a richness and depth of detailed information.
Krueger stresses that a key feature of focus groups is the influence that group members have on each other as the discussion unfolds and they respond to each others' ideas, and that this reflects the reality of how people develop their perceptions, as well as increasing the depth of understanding as to why these opinions are held [84]. Focus groups not only allow, but actively encourage the respondent to elaborate on their answers by providing examples, or explaining reasoning or emotional reactions. A focus group typically comprises 7 to 12 participants who are selected on the basis of certain shared characteristics which relate to the issue in question. This homogeneity enables trust to develop within a group, which in turn encourages disclosure. The aim is not to reach a consensus view or to generalise to the broader population, but to understand and determine the range of how individuals perceive the issue in question.

There is a coherence between the methods used and the information sought in focus groups and the communication skills taught in this course. When Krueger describes focus groups as allowing evaluators to "see reality from the (participant's) point of view", there is a strong resonance with the concept of patient-centredness [84]. The same theme repeats itself throughout this study – the development of approaches which are concerned with seeking an in-depth understanding of the process, context and richness of individual experience in medical interviewing (patient-centredness), medical education (simulated patients) and evaluation (focus groups) to provide balance to the traditional, reductionist paradigms.
There is also coherence between the skills required of the moderator in a focus group and the communication skills taught in the course – open-questioning styles, probing, attention to verbal and non-verbal cues and so on. The questioning route also has similarities with the medical interview, with rapport building followed by open questions, which gradually become more focussed on the issue(s) of prime concern, before closing with a summary and check-back with the patient or participant.

From a pragmatic point of view focus groups offer the advantages of relatively low cost, and speedy results – important when the planning of the next year’s course commences almost before the preceding course is completed.

The Focus Group Processes

Structure of Groups

Five focus groups were held in 1995:

- one of a sample of eleven students;
- Two tutor focus groups involving
- eleven of the sixteen tutors; and
- Two simulated patient focus groups involving all ten simulated patients.

To this data was added the information gained from 2 focus groups with tutors in 1996, and a questionnaire distributed to all 1996 students.
Group Size

Krueger recommends groups of 6 to 12 participants [84]. The group must be large enough to provide diversity of opinion, and to benefit from the group dynamics, but small enough for everyone to have the opportunity to speak, and to avoid fragmentation into sub-groups.

The 1995 focus group with medical students consisted of 11 participants. Eleven of the 16 tutors attended one of the two focus groups. All ten simulated patients participated in one of two focus groups.

Recruitment and Selection

The only specifications for the focus group for students was that the participants be third year medical students who had just completed the course, come from a range of different tutorial groups, and include both males and females. A notice was placed on the third year bulletin board, seeking students to participate in a focus group to evaluate aspects of the Communication Skills Course. Lunch was offered as an incentive. A student who approached the convener early in the recruitment process was asked to encourage other students to participate, bearing in mind the above specifications.

Eleven students who met the above criteria expressed interest in participating, and these formed the focus group. They came from 8 different tutorial groups, consisted of 7 males and 4 females, had diverse ethnic backgrounds, and represented a wide range of career aspirations within medicine. During the pre-
session small-talk it was determined that they were not a pre-established social

group of friends, nor did there appear to be any background dynamic which

would influence the process of disclosure and discussion. Indeed, some group

members had never spoken with each other, and were virtual strangers, despite

having spent three years together in the same course, such is the size of the

medical cohort. The pre-session period, including the provision of lunch, was

designed to establish a warm, friendly environment conducive to open
discussion.

All tutors and all simulated patients were invited to participate in the evaluation,

which is unusual for focus groups, which usually involve a sample of the total
target population. Those tutors who did not participate in the focus groups had

other meetings or appointments which clashed with the times of the focus groups,

and were not in any other way distinguishable from the participant tutors.

Recording

The focus groups were audio-taped and later transcribed as fully as possible,
given some technical difficulties such as people talking simultaneously. An
assistant moderator also took written notes during the sessions, particularly trying
to highlight comments that encapsulated general themes in the discussion. Both
these processes were introduced to each group at the beginning of the session as a
means of recording the proceedings.
Participants were also assured that comments would not be personally identified, and that their honest feedback was sought, including any negative comments.

**The Questioning Routes**

For the 1995 focus groups, formal questioning routes were prepared (Appendices 4-6). An open-ended questioning style was used so that the responses were not implied or constrained by boundaries. The respondents could therefore determine the important issues from the perspective of their experiences, and could comment, elaborate, illustrate or explain as they saw fit, with the moderator modifying the questioning route if required.

Particular care was taken with the introduction which included a welcome, an explanation of the areas of interest and the purpose of the focus group, and the establishment of ground rules, before leading on to the first question. This first question was designed as an “ice-breaker”, which each participant could answer in turn.

Following the model set out by Krueger [84], the questioning route moved through Introductory Questions to encourage conversation between the participants on the general topic of discussion; Transition Questions which start to focus the participants on the particular issues of concern, and the Key Questions, from which the most specific information would be gained.
At the end of the session the moderator summarised the main points arising from the discussion and checked the accuracy of these with the group. The group was then asked for any additional comments before the interview finished.

The Moderator

In focus groups, the moderator is careful not to direct or dominate the discussion or influence the perceptions of the respondents by indicating their own points of view - either verbally or non-verbally. While a carefully planned question route provides structure to the discussion, the moderator needs to be flexible and sensitive to issues raised by the group that may indicate a need to vary the pre-determined route. Thus, while the moderator appears superficially to be passive, he or she is, in fact, highly alert to the group process and direction. The moderator should be experienced in working with groups, but also be knowledgeable about the issue under evaluation so that they can identify important issues as they arise, subtly steer the group back on track if the conversation strays, and understand the context in which the discussion occurs. The moderator must be able to formulate questions articulately and concisely “on their feet”. [84]

While the moderator subtly directs the discussion, an assistant moderator can be invaluable to take notes, operate the tape recorder, and respond to unexpected interruptions [84].
In the first year, the author took on the role of moderator, as there was not yet an issue of strong identification with the course or the use of simulated patients. In the following year, an external moderator with considerable experience ran the focus group with tutors, as the author had by then taken over the role of course co-ordinator and was therefore more identified with the course, which could have influenced disclosure. This external moderator was briefed by the author as to the nature of the course, the use of simulated patients and the topic(s) of interest for the focus groups. The external moderator developed a topic guide (Appendix 8) rather than a formal questioning route. This had the advantage of appearing more spontaneous, however some questions became convoluted and complex. The external moderator also referred to findings and insights from the first focus group in the second, which is an acceptable technique in focus groups, but there is the danger of inadvertently leading the participants towards pre-conceptions and assumptions developed in the first group. A formal questioning route may take longer to prepare and rehearse, but through this process subtle differences in language can be corrected and the questions checked for wording, bias, unidimensionality and length.

Analysis

Analysis of data from 1995 focus groups

The author participated in each of the 1995 focus groups as moderator, and thus analysis really commenced during the focus groups themselves. Initially, general themes which emerged from the interviews, and which were relevant to the research questions, were identified, refined as categories and structured as
headings using a word processor (Word 6). The full transcripts and field notes were then examined and categorised according to these general themes. The word processor was used to “cut and paste” quotations under these headings as appropriate. Both the content and context were considered – when required a portion of the tape from an interview was re-listened to, to check the tone of voice or intensity of particular comments. This more intense analysis of the data indicated the need to further refine the categories - new headings added, and some existing headings further subdivided. One of the strengths of qualitative analysis is its flexibility and responsiveness to emerging themes which may not have been included in the initial framework.

Interpretations were suggested which explain the majority views, and contradictory responses were sought. Efforts were made to identify perceptions at variance with the majority, and possible explanations considered. As the analysis proceeded, different insights and perceptions were invited to clarify or verify some of the themes, especially from the supervisor of this study, but also informally from tutors, simulated patients and subsequent students.

**Triangulation**

A different method for collecting feedback from students was used the second year to achieve triangulation, which involves using different research methods when considering the same issue to confirm initial findings, and obtain both depth and breadth of information. In 1996, written feedback via anonymous questionnaire was sought from the students (appendix 7), again providing
qualitative information, but representing a broader spectrum of students. The questionnaires also sought more general feedback on the course, and were distributed during the second last lecture of the subject of which Communication Skills was a part - *Family and Community*. The questionnaires were distributed and collected by the subject co-ordinator, who is held in high esteem by the students, but has no direct involvement in the Communication Skills course. Unfortunately, return rates were typical of this form of evaluation, being 42.2% (87 returned from 209 students). Nonetheless, having identified the major themes and issues in the first year, the information gained from the questionnaires was useful to check these findings, monitor the progress of the educational processes and identify any new themes that might suggest the need for further in-depth evaluation. There was a remarkable similarity in the feedback from the students from the different years, using the different methods.

Focus groups were again held for the tutors (appendix 8) in 1996, with an external moderator as discussed above. Because this is a small group, all tutors could be involved in one of the two focus groups held, and so both breadth of representation and depth of feedback could be achieved. It became apparent that the focus groups also served the purpose of debriefing for the tutors at the end of the course.
Analysis of data from 1996 student questionnaires and tutor focus groups

Quotations from the transcript of the tutor focus groups and the student questionnaires were entered under the categories used for analysing the data from the focus groups in the first year. Relevant quotations from the questionnaires were taken from the specific question on the use of simulated patients, as well as the “Other Comments” section (Appendix 7). Again, the in-depth analysis led to further refinement of these categories and the development of new headings. At the end of this process, the transcripts from all focus groups and the responses to the questionnaires were re-read to check the accuracy of the analysis.

The Integrated Analysis

The evaluation is organised under the following headings: realism; competence versus performance; transition from theory to real patients; influence on students' approach to learning communication skills; increasing students' self-awareness of their own communication skills; observing others interviewing the standardized, yet responsive patients; feedback; rehearsal and resumption of interview and general comments. In each section the integrated analysis from both 1995 and 1996 is presented, including typical or illuminating quotes, and compared with similar evaluation of equivalent courses published in the literature, where relevant. The quotes are identified by source and year which also indicates the data collection method thus: Focus Groups – Student 1995; Tutor 1995; Simulated Patient 1995; Tutor 1996. Written Questionnaire –
Student 1996. To improve clarity, some comments have been abridged or modified, but this is clearly indicated in the quotation.

While the division between Educational Process Issues and Learning Issues is useful when considering the theoretical basis of the use of simulated patients, it is less useful when analysing data which reflects participants’ real experiences. The separation between these two concepts becomes blurred and artificial, especially when the educational process was specifically chosen to match the learning processes. The participants - including the tutors - are more concerned with and aware of learning issues or the substantive content rather than pedagogical strategies, and the form of their feedback reflects this.

**Realism**

The most fundamental issue is whether verisimilitude was achieved. There were many comments from the students, tutors and even simulated patients themselves about the realism of the interviews, which matched reports from similar programs elsewhere [6, 41, 71]:

- “*It gave a sense of reality, I think, having the simulated patients.*” (tutor 1995)
- “*It was very realistic.*” (student 1995)
- “*All of the simulated patients were very good. It didn’t feel as though they were simulated - they kept their roles very well.*” (student 1996)
- “…*the actors played their roles very convincingly.*” (tutor 1996)
- “*it really felt real*” (simulated patient 1995)
• "On the whole, very good. They were convincing and allowed valuable time to practise the material." (student 1996)

• "Excellent. Gives a realistic twist to the doctor - patient interview." (student 1996)

Sometimes the students were so drawn into the verisimilitude of the role-play that they needed to define the boundaries after the role-play:

• "Re realism - one student asked if my character was getting married and afterwards the students said to me "Are you really getting married at Easter?" (simulated patient 1995)

The evaluation is concerned with the introduction of simulated patients to the pre-existing Communication Skills course, in which previous students only had the opportunity to interview each other in role-play, for both learning and assessment. Thus the critical comparison to be made is the students’ experience of the reality of their interaction with simulated patients compared with role-play with their peers, as they had been doing throughout the tutorials. Also, as this course is designed as an introduction to interviewing skills before students move into the clinical component of their course, they have yet to interview real patients, and cannot therefore compare this with interviewing simulated patients.

• "They are better than interviewing other medical students..." (student 1996)
• "It's hard when you've got a medical student (role-playing the patient) because even before you start they have given you half of the information, very helpful." (student 1995)

• "Great. I'm glad we have simulated patients rather than interviewing other students - a little more realistic." (student 1996).

• "This is mandatory for the video interview - can't really use tutors or fellow students." (student 1996)

• "Very good...using other students as patients was unproductive." (student 1996)

• "The actors are much better (than students) at sticking to their imaginary story and inventing details". (student 1996)

• "Good. Nicer than talking to peers or tutors - where there's an air of falseness or pretence." (student 1996)

• "Extremely useful (rather than practising among ourselves)." (student 1996)

• "It made the situation more realistic." (student 1996)

• "...makes it a lot more realistic and a lot more scary !!!" (student 1996)

For some students, the difficulty was not so much interviewing other students in role-play, but having to portray patients themselves. There are, however, strong educational merits in students role-playing patients, as it enables them to experience first-hand the patient's perspective, as discussed earlier. Thus, while it is beneficial to use simulated patients who are able to act more effectively than students, the students should still have an opportunity to "enter the patient's world" - perhaps especially those students who find this difficult.
• “Excellent! Should have more if possible. It is hard to have to pretend / role play”. (student 1996)

• “We all know each other fairly well and it was difficult to pretend to be someone else...The actual actors...were really good.” (student 1996)

• “This was a good idea because I found it very hard to do role plays with my own classmates. It was harder to be serious with people you know and awkward at times.” (student 1996)

• “I think it brightened up the whole course immeasurably. I thought it was great. I think we should have much more of it. It’s just so much better than role playing with each other. You just can’t compare it.” (tutor 1995)

Some students recognised the advantages in students taking on the patients’ roles in some of the sessions, however -

• “Good that students play the role of patients, we understand how patients feel better this way.” (student 1996)

Nonetheless, it should be acknowledged that these interviews can only ever be an approximation to reality, and some students commented on this. The sense of unreality is exacerbated by the use of the video-camera, the unrealistic physical setting (the corner of a tutorial room), the enforced time constraints and the anxiety of summative assessment and forthcoming observation. To quote a
student in a similar program in Western Australia: "The patient was realistic, but the setting wasn't." [41].

Taking all of this into account, it is perhaps surprising that relatively few students commented that the experience was artificial, and felt that this affected their performance (all such comments included):

- "Not terribly convincing and the video is a very unnatural environment..." (student 1996)
- "Sometimes hard because of it being a fake situation" (student 1996)
- "Difficult, because the situation was a bit artificial. But the patients were all very friendly and communicative, and probably had backgrounds similar to "real" patients we might encounter." (student 1996)
- "Using actors as patients for the video sessions made the situation slightly artificial, but this can't be helped." (student 1996)
- "Of some use. It is still a very artificial situation." (student 1996)
- "While still not completely realistic, it is a good option." (student 1996)

The simulated patients and tutors also commented on this aspect:

- "I found the students I had were very earnest, some of them were painfully nervous and I don't know whether they were more nervous because of the fact that they were being videoed or because this is an actor, but they were very nervous." (simulated patient 1995)
"I think a lot of their nerves was to do with the camera being focused on them." (tutor 1995)

However, Jenkins reported on the frequent experience of his trainees that once the consultation began they became oblivious to their surroundings [14]. Some of the third year students had similar experiences:

- "Because you are looking at the patient, you can't really see the camera."
  (student 1995)
- "You would expect that after a minute or so you would lose your inhibitions."
  (student 1995)

It is a common experience for neophytes in any capacity to feel uncomfortable and artificial when they begin to interact in their professional role. For the medical students to learn to take a formal, relatively structured social history, which entails primarily a one-way flow of often deeply personal information, is unusual and quite outside most peoples' experience of interpersonal communication. Comments from students such as: "...the actors' roles were a bit "stiff" - not conversational" reflect the reality of the student learning to take a structured medical history. As a neophyte is socialised into the medical profession they adopt a series of formal roles, which can be recognised by the external symbols such as the short white coat of the medical student in hospital, which is replaced by the long white coat of the graduate; the wearing of the stethoscope draped around the neck, and the pockets bulging with the tools of the
trade. Indeed, it is sometimes the dropping of these external symbols that marks
the maturation of the neophyte into a comfortable, internal identification with the
"doctor's role" - the integration of the person with the professional.

- "Not bad, but the situation tends to be a tad unrealistic - the students
  themselves tend to end up "acting" as well, as the interview tends to be a little
  forced and unnatural." (student 1996)
- "...the actors' roles were a bit "stiff" - not conversational." (student 1996)
- "...it is still a bit false - you are acting and are more worried about what you
  are doing than about the patient. I didn't like this aspect of it - encourages us
  to act in future meetings with patients! However I did still learn some
  important skills, and some form of practice is necessary." (student 1996)
- "Helpful, but as a student I felt I was a simulated interviewer rather than an
  actual undergraduate applying interviewing skills. Perhaps more practice
  would be helpful." (student 1996)
- "Seems a little "artificial", like putting on a role. As a result, I, too, tend to
  assume a role". (student 1996)
- "Most of the students find it hard to sustain the 7 - 10 minutes asking
  meaningful questions, probably because they are fully aware that the
  interviewees are actors, and therefore cannot generate genuine enthusiasm or
  interest in the topics covered. It became more of an acting lesson than a
  genuine application and demonstration of communication skills. It is difficult
  to practise the right "process" without an interest in the "contents"."
  (student 1996)
One of the simulated patients even suggested that the students might benefit from some formal acting training:

- "...maybe for some of them it may be an idea to have an acting teacher in and giving them a few drama lessons just to free themselves up." (simulated patient 1995)

This suggestion has actually been made before, by Drs. Finestone and Conter in an article in The Lancet in 1994 [85]. They argue that as a doctor is “expected to assume a role” in responding appropriately to different situations and different patients (the core of patient-centredness), formal training should be included in the medical curriculum, to raise doctors’ awareness of their expressive behaviours.

Overall, the majority of participants strongly supported the realism of the simulated patients, particularly in comparison with student role-plays of patient presentations. Only a few students in the two years of evaluation commented that the experience was artificial, and many of their concerns could be attributed to factors other than the simulated patients themselves, either relating to the setting or the acknowledged self-consciousness in learning to take a structured social history. Having established the versimilitude of simulated patients for most participants, the analysis is next concerned with the learning opportunities
available with this educational method, especially those over and above the other methods available for teaching communication skills.

**Competence versus Performance**

There is often a wide gulf between theory/competence and practice/performance as discussed earlier in this thesis. Many of the skills the neophyte must learn on their journey to becoming a professional can appear deceptively easy, and even common sense, when learning the theory or observing the skilled practitioner. However, what is not apparent to the observer are internal processes of analysis, reflection, and selection of a measured response, which are the real skills to be mastered. Actual performance can therefore be surprisingly difficult, and thus highlight to the students the importance and nature of the skills to be learned.

- "They think "This looks easy", but it wasn’t quite that simple..." (tutor 1996)
- "They were watching someone else... and they realised how difficult it was..." (tutor 1996)
- "It was difficult, a lot more difficult than they imagined" (tutor 1996)
- "I learnt a lot more than I thought I would... it makes you really think about what you are saying." (student 1995)
- "It’s only when you really think about talking to patients that you realise it’s really very difficult." (student 1995)

For some, the performance of the skills helped to consolidate their understanding:
• "The simulated patients allowed us to practise what is basically just theory."
  (student 1996)

• "Very good. It put it all together which was very helpful." (student 1996)

Thus, as well as consolidating knowledge, and providing the students with an opportunity to practise the skills of effective communication, the interaction with the simulated patient also served to raise awareness of the complexity of doctor-patient communication.

**Transition from theory to real patients**

Moving from the theory of the pre-clinical years to real patient contact is a big adjustment for many students, and they express the anxiety common to many neophytes. The use of simulated patients as a "stepping stone" between the pre-clinical years and the students' first interactions with real patients can provide a safe, protected, yet still realistic, environment for students to practise their skills, with therefore less danger to the real patients the students first encounter. This is not to deny, however, that the process of interviewing simulated patients is, in itself, anxiety provoking. Some studies have reported that up to 30% of students were anxious prior to the simulated patient interview [41], which may in part be exam anxiety, or anxiety about the videotaping process, rather than due to the interaction with the simulated patient in itself. Most calmed down as the interview progressed, and Hasle showed that prior exposure to simulated patients
resulted in a reduction in anxiety when the students then had contact with real patients [cited in [41].

- “Great! I guess we’ve got to do it sometime…As the first time that we do it (interview a patient), I was grateful that they were indeed simulated - God forbid that I make the mistakes I made with a real patient!!” (student 1996).
- “It was good to be placed in that situation …before reaching the clinical years.” (student 1996)
- “I would have been in a lot of trouble next year going straight into the hospital…with real patients.” (student 1995)
- “Good. Wasn’t as threatening as having real patients.” (student 1996)
- “A good idea, as it was more like the situations we will be exposed to in the future.” (student 1996)
- “…that’s how you would feel with your first patient, you would actually feel nervous.” (tutor 1995)

Some students indicated that they needed practice to overcome some very rudimentary communication hurdles –

- “Fairly useful in the sense of just getting you to open your mouth, i.e. talk and communicate.” (student 1996)
- “I think this is a very good idea because it allow us to actually try talking to people who we don’t know anything about.” (student 1996)
• “Helpful - it was good to practise your communication skills on someone you’d never met before and knew nothing about” (student 1996)

This was also commented on by the simulated patients:

• “I was actually quite surprised in many ways, I will be honest and truthful here, that the communication skills in 3rd years were very lacking... They were very pleasant but they didn’t seem to know which tack to take - how to communicate with a person they had never met before and find out things about their personal history...” (simulated patient 1995)

Thus, the comments in this domain highlight that not only is beginning to interview patients often a significant challenge for the medical students on their path to becoming doctors, but that they appreciate a transitional step, and they perceive practising with simulated patients as equivalent as interviewing real patients.

Influence on students’ approach to learning communication skills

For many students, exposure to simulated patients emphasised the importance of communication skills to medical practice. They therefore approached the course more seriously, and may also be more aware of communication issues in their ongoing clinical experiences.
• "It really did transform the students' understanding and expectations" (tutor 1995)

• "certainly added a new dimension" (tutor 1995)

• "I thought it went very well compared to previous years. When you have the student with the student (in role-play), often they did not take it very seriously..." (tutor 1995)

• "They were a lot better this year, their communication skills were all better... (previously) they did not take it quite so seriously..." (tutor 1995)

• "Some were just so dull and uninteresting (in previous years), whereas with the simulated patient they themselves (the students) really got into it very well, and I thought the videos this year were the best that I have viewed" (tutor 1995)

• "I felt that the students were earnest and wanted to take it seriously." (simulated patient 1995)

• "... I just thought the purpose of this was sort of as an introduction. It's not as if you expect to do 8 weeks or 10 weeks of this and you a pro doctor, you know you're a gun at taking a sexual history, you're a gun at communication. I thought it was just an introduction and it helped in the transition from now into the hospital because the hospital is primarily another practice session except that they are not simulated patients, they're real." (student 1995)

As perhaps would be expected, most of the comments in this domain were from tutors who were the only participants able to make comparisons with previous years, i.e. with the course prior to the introduction of simulated patients. By
using simulated patients, assessment of the course became more standardized, more valid and reliable (as discussed earlier in this dissertation), and students picked up on this by approaching the task more seriously.

**Increasing students' self-awareness of their own communication skills**

The combination of watching themselves on video, observing their peers interview the same patient and receiving detailed feedback raised students’ self awareness, and helped them identify their strengths and weaknesses in communication. In a similar program in Western Australia, students reported that by observing themselves on video, they became more aware of their body language, questioning styles, listening skills and the importance of exploring the patient’s social context [41]. One of the less overt objectives of the course is that students begin to develop the practice of self-assessment and reflection on performance, and use intrinsic feedback in the consultation. This is one of the characteristics of achieving “independent action” as described by Miller [42], and described earlier in this thesis.

- “*Very useful, especially the video making because we get to look at ourselves - the way we handle situations. It's a chance for us to improve on our communication skills.*” (student 1996)
- “*You could see how valuable it was for them to actually watch themselves.*” (tutor 1995)
- “*The video was fantastic. It was embarrassing to actually see how often you interrupt people or you don't let them finish their sentence and things like*
that. Because I didn't realise what I did, like I asked a couple of really convoluted questions and I didn't realise until I saw it on the video.” (student 1995)

- "...it was useful to see myself on the video and obtain critique (sic) on one's communication skills.” (student 1996)

- “It's so easy to get arrogant without even realising it. That was a bit scary. Like assuming things...” (student 1995)

- “I feel a lot more confident about interviewing patients - I didn't realise I was that competent” (student 1996)

- “Very good. Gave us a guide as to how we were progressing.” (student 1996)

- “I found the video making section highly valuable - allowed me to focus on strengths and weaknesses and gain confidence.” (student 1996)

Thus, even these relatively few comments suggest that not only did the students become more aware of the importance and complexity of doctor-patient communication, but that viewing themselves on videotape interviewing a simulated patient provided an opportunity for increased self-awareness and self-assessment.

**Observing others interviewing the standardized, yet responsive patients**

One of the most powerful learning opportunities was that students could observe their peers interview the same patient, and observe the impact on the interview of different approaches. The communication skills are taught within an outcome-
based framework. Students are encouraged to select specific communication approaches for the particular outcomes they are trying to achieve in the interview. For example, open questions are useful for helping a reserved patient to open up, but are counter-productive with a garrulous patient the interviewer is trying to keep on track. No single communication skill is the right skill in every situation. The analogy that is often presented to the students is that communication skills are like a bag of golf clubs. The interviewer, like the golf player, surveys the terrain, establishes their objective(s), and chooses the club / skill that is most appropriate. The importance of mastery and comfort in using a variety of skills is also highlighted by this example. However, these analogies are just abstract, and nothing can surpass the power of observing the effect of different skills with the same patient.

Our findings are consistent with those of Jenkins, working with General Practice Trainees [14], and supported by Ladyshewsky et al [42], whose students appreciated the opportunity to observe other students with different approaches, and this reinforced the communication skills training. Interestingly, the students in that study requested the opportunity to observe interviews with the same patient they had themselves interviewed, as is done in the course at the University of Melbourne.

- "A fascinating thing that came out of it...(was)... that each student got something different from the history of the patient they were with, depending on the details or questions they asked or the emotion that came through, but it
was really interesting, I thought, for them to see how the one person, with the one story, who was constant.....how almost a totally different picture and feeling could come through, and I thought that that was a valuable thing to be able to get them to see how some of the good communication skills can really draw out a lot more to get the feeling of what was going on than someone who has just got a check-list and the typical clerking that we learn in hospitals.” (tutor 1995)

• “They were learning in two different ways - how they went and then also learning from everyone else, seeing that different skills can bring out different emotions in different parts of the story” (tutor 1995)

• “They did seem to get more by sitting in on one another, more than I thought they would. I thought they would be bored silly, but it worked better than a lot of people thought.” (tutor 1995)

• “Because every students is different, you get a different aspect.” (tutor 1995)

• “They will sit and say: “Oh, my transition from topic to topic wasn’t any good in comparison to the first person”, but, in fact, theirs was excellent, they just did it in a different way.” (tutor 1995)

• “It was quite good as the student could see it... that they get different information by asking different questions and emphasising different things.” (tutor 1995)

• “It was helpful, that was good... because you go to see how different people, like some people got out different, more personal information and their style of communicating was more successful in dealing with personal issues, and
people who weren’t able to elicit that information could see how important it was.” (student 1995)

- “I think you learn from watching other people.” (student 1995)
- “One of the things I noticed just looking at my own [interviews] - I was very consistent, so when they actually saw them all together they could actually see that different techniques got different [responses].” (simulated patient 1995)
- “I was surprised to see how easy it was to respond to each different style of questioning, it was a lot easier than I imagined it was going to be in the training session, because the techniques are quite different and you respond quite differently to each person. It was rather interesting.” (simulated patient 1995)

An underlying assumption in teaching communication skills, is that different approaches in communication will lead to markedly different outcomes in the interview. This theory becomes reality when observing different people interviewing the same (simulated) patient. Even some of the tutors, who have been actively teaching the theory, were impressed by the power of this in practice.

Feedback

Students appreciated the opportunity to get feedback on their skills from the simulated patients, and regarded this feedback as credible. In a similar program in the UK, McManus et al. reported that an overwhelming 99% of their students rated the feedback from the simulated patients as “very” (68%) or “quite” (31%)
useful [6]. Pololi described similar enthusiasm, and was also able to report
greater expertise and efficacy in students who had received such feedback
compared to their peers who had not, as measured in examination performance of
these process skills [71]. The findings of Stillman et al. and others, also support
this positive response to feedback from the simulated patients [14, 28, 33, 38].

Such specific, constructive feedback is not readily available from any other
source, even less so after graduation. Occasionally students and medical
practitioners receive indirect or vague feedback, such as: “The patients seem to
like you”, “You’re always so helpful.” or “You were recommended to me by
another patient.”, but these do not really help identify the specific aspects of the
student or doctor’s performance that are appreciated. Rarely does such feedback
focus on the less effective attitudes or behaviours, unless the situation is so
extreme as to warrant medico-legal intervention. Although interpersonal skills
influence a patient’s choice of doctor, other factors also contribute to whether
patients return to the doctor or not, such as availability, accessibility, convenience
or habit.

Thus it is important to maximise the student’s opportunities to receive detailed,
credible feedback while undergraduates, and before their interpersonal skills have
become ingrained.

- “I think it was good having the patient there and them telling you exactly how
  they were feeling.” (student 1995)
• "...it was good to get that back from the patient. to hear the patient say:
  "Yeah, I felt you were warm or I felt you were nervous", and that kind of
  thing, well, you don't know that about yourself." (student 1995)

• "...you get a lot more out of it, it's really good." (student 1995)

• "I thought that was really good because sometimes the tutor would give you a
  personal view point on something you had done.....and say whether they liked
  it or whether they thought it was inappropriate, but then the patient could
  actually disagree and say: "Well, I really liked that", and it just gives you a
  lot more to think about. Its more constructive than just saying: "well, don't
  do that."" (student 1995)

• "This is a great idea! It allowed me to experience what it is like to interview
  a patient and actually getting feedback on the positive and negative aspects of
  my communication skills." (student 1996).

• "Excellent. Provides a useful feedback on ourselves." (student 1996)

• "...it is good to receive feedback from the tutor, the patient and friends."
  (student 1996)

• "...great to get the patient's feedback." (student 1996)

• "It's important for practising and getting feedback." (student 1996)

• "It was also good that you try a few things out.....I tried one way and said:
  "Well, did you get offended by it", and she (the simulated patient) said "No",
  and so I knew that in that case it worked.....I mean next year you can't really
  ask the patients that.....because like they will get offended or whatever."
  (student 1995)
This was echoed by the tutors -

• "They certainly gave a richness and a depth to the feedback that wouldn't otherwise have been there." (tutor 1995)

• "I thought it worked very well, to get direct feedback from the simulated patients. The three I had were very good, they really didn't hold off. I mean sometimes I would have though "how can I be a bit softer", but "bang" - straight into it. Being actors also they were prepared to say things and that led to good discussion that I thought was really worthwhile." (tutor 1995)

• "I thought it was excellent, it just made so much difference in the debriefing, having done it before, it made such a big difference having their feedback....it really gave additional insight that we don't normally have. I felt that it really gave another completely different perspective to the interview." (tutor 1995)

• "...there is a real unknown person in that group that they have to talk to and it makes it more real for them and it also makes it more unknown because that person is not going to be their friend and say that was all OK, even if it wasn't." (tutor 1995)

• "Actors gave very good and appropriate feedback." (tutor 1996)

There were some cautionary comments, however:

• "Just a couple of times, I felt that they overstepped the line just a little bit. They started giving comments on content or other things which I didn't think was appropriate, But the good really outweighed the small negative." (tutor 1995)
• "...don't be afraid to pull rank, I reckon. Quite frankly, they are there as simulated patients, they are not there as teachers, but they have got important things to say because they are reacting as the patient, so I guess we just have to be in control." (tutor 1995)

• "I found they blurred the lines a little bit and I sort of reined them in." (tutor 1995)

• "...the criticisms should be constructive rather than destructive, and it is up to us as tutors to try and round it off and smooth it. I don't mind if they come up with a few sharp edges." (tutor 1995)

Overwhelmingly, the comments about feedback from the simulated patients were positive, apart from the few cautionary notes, which really related to the interaction between tutor and actor.

Rehearsal and resumption of interview

Having the simulated patients participate in the debriefing sessions provided the opportunity to resume the interview, and immediately apply approaches that had been developed through discussion of the feedback. This is a particular and very powerful learning opportunity for repetition and reinforcement which can realistically only be provided by the use of simulated patients. Unique skills of improvisation, responsiveness and sheer memory are required to resume an interview at any point, and respond authentically, while participating in a feedback session.
• "it was very good that when students brought up "Well, I might have done this..." to be able to say "Well, why don't you do it now", or "Ask the patient now" or whatever." (tutor 1995)

• "I thought it was fantastic to have the simulated patients still sitting here and the students saying that "I didn't do this very well" and then say "Well, how could you have done it better" or "Why don't you try that now"...often that was very valuable I thought." (tutor 1995)

• "...try it out and if it doesn't work it doesn't work..." (student 1995)

• "...what we said before about redoing the different ones, I found that was a really powerful experience for the student, I thought, to actually redo bits of it, they learnt a lot. I thought that was a really good way of learning."

(simulated patient 1995)

Some of the simulated patients found this a difficult process. The difficulty seemed to occur if they gave feedback out of role, and then had to resume the role for rehearsal of a particular skill. Those simulated patients who stayed in role (albeit as an articulate and insightful version of the character) were able to resume the interview more smoothly. This observation supported the advice in subsequent years that simulated patients provide feedback in role, which also adds the authenticity.

• "...I think it worked in some ways and in other ways it backfired." (simulated patient 1995)

"...if they were asking me to give feedback as myself and then slot back into redoing the interviews it was very difficult." (simulated patient 1995)
This domain only generated a few comments, and it appeared to the author that only a minority of tutorial sub-groups had availed themselves of this opportunity. As it is quite a sophisticated educational technique, it seemed to require a match of an experienced, confident tutor, with an experienced, confident actor who were both prepared to work within a more opportunistic tutorial structure. However, when attempted, the comments suggest that it worked well.

**General comments**

Most found the experience with the simulated patients not only useful, but enjoyable, which is consistent with the findings of other similar programs [14, 28, 33, 41, 80]

- "**Video taping experience very helpful and fun (after the event).** Most practical way of helping us improve our communication skills." (student 1996)
- "**Fantastic to have such practice made available.**" (student 1996)
- "**A very stimulating part of course.**" (student 1996)

And finally:

"**very useful - more please.**" (student 1996)

"**Very good - Excellent**" (student 1996)

"**Excellent - I cannot think of any better way to learn.**" (student 1996)

"**Fantastic**" (student 1996)
Chapter 5: Developments in the use of simulated patients since the evaluation

Fifth year teaching

When simulated patients were recruited and trained for the third year course, it was decided to also use them in the Fifth year General Practice rotation. Exposure to the simulated patients through the recruitment and training processes created enough enthusiasm among members of the Department of Public Health and Community Medicine, that other potentials for their use in medical student education were identified.

A quarter of the fifth year students rotate through the General Practice term at a time, the rest of the year consisting of rotations in Obstetrics and Gynaecology, Paediatrics and Psychiatry. The General Practice rotation consists of a series of lectures, tutorials and practical classes, and attachments to metropolitan and rural general practice.

The students are rostered to conduct a videotaped medical consultation with a simulated patients, portraying a patient with a common presentation in general practice, such as hypertension, asthma or gout. The examination findings are presented on a sheet of paper when the student indicates that they would conduct a physical examination. The video is used for formative assessment in one of the tutorials, and as such, is viewed by the tutor and the 6-7 other members of the
tutorial group, who also provide feedback. None of the students in the same
tutorial group interview the same patient. The simulated patients do not provide
feedback to the students.

The simulated patients are also used in the assessment of the rotation, which is
done by written paper and OSCE (Objective Structured Clinical Examination).
The OSCE consists of a series of 10 minute stations designed to assess the
students clinical performance. The students are divided into eight groups of
approximately 6-7 each, four of which are examined simultaneously at two
different sites. The simulated patients are used in the Diagnostic and
Management Process stations, in which the students conduct a consultation with
a simulated patient designed to assess their skills in the process of formulating a
diagnosis, and excluding other hypotheses in the former; and formulating and
negotiating a management plan with a patient in the latter. An examiner observes
these interactions, and marks the student according to a pro-forma. The
simulated patients attend a specific training session on their case prior to the
examination, to ensure standardization among the four patients who will be
portraying the same patient at the different exam sites. Although the simulated
patient does not directly assess the student, the examiner checks with them about
the consultation from the patient’s perspective, e.g. rapport, clarity of explanation
etc.
The new medical curriculum

A new problem-based medical curriculum commenced with the 1999 first year students. One of its hallmarks is increased integration between the clinical and pre-clinical years and between the content and process of clinical practice. Introduction to Clinical Medicine is a vertical stream which continues through each of the first five semesters (2 1/2 years) in which the students learn the fundamentals of taking a structured medical history, and undertaking a systems based physical examination. The first semester of this stream is basically the Third Year Communication Skills course from the “old” curriculum, with a few modifications, including 3 half-day clinical attachments, during which students sit in on consultations between doctors and their patients. To focus the students’ observations of doctor-patient communication, they are provided with particular tasks for each clinical attachment.

Simulated patients are used in this first semester course the same way they are used in the third year course detailed in this dissertation, including the giving of feedback. Simulated patients are also used in the teaching and assessment of subsequent semesters in this stream which focus on particular body systems, for example, Nutrition, Digestion and Metabolism in semester 2. The students alternate between tutorials based in the teaching hospitals or other clinical sites, such as general practice, and on-campus tutorials which may include learning from videos, practise with each other or simulated patients.
This new curriculum thus incorporates two of the proposals which arose out of the evaluation which is the basis of this thesis: increased exposure to simulated patients, and integration with interviews with real patients.

**More exposure to simulated patients**

It is perhaps an affirmation of the success of the use of simulated patients that both students and tutors suggested that they be used more often. They are a relatively expensive educational tool, and funding limitations currently restricts their use to the final tutorial and assessment of the third / first year course, and limited use in the other semesters. There is the temptation to squeeze every drop of educational value out of them during these brief contact with students, which can lead to complications in their use, and thus muddying of their impact, for example, the potential for conflict between formative and summative assessment. The evaluation of their use has been positive enough to suggest that increased use of simulated patients throughout the medical curriculum would be beneficial in the teaching of communication/clinical skills, if their use was specifically targeted to those opportunities when the educational objectives matched the unique opportunities afforded by simulated patients. The new curriculum offers the opportunity for this, particularly throughout the Introduction to Clinical Medicine course.

- "**More opportunity for them to do it! Because the next people they practise on are real.**" (tutor 1995)
- **There should be more simulated patients.**" (student 1996)
• “I think that it's a shame that the first and second years don’t have a chance at even a couple of sessions to try and look at the practical side of communication skills.” (student 1995)

• “I think it would be great..like every six months you had an actor and you have to take a history just to see how you’re going.” (student 1995)

Incorporation of real patients with the specific purpose of practising communication skills

While some students felt that nothing could replace real patients, this dissertation has already considered some of the issues regarding this, such as availability, ethical concerns, patient safety and student comfort. An option would be to link the stages in the transition from theory, through peer role-play, then simulated patients to real patients more explicitly within the one course. Thus students could be exposed to the theory of a specific set of skills or a defined communication challenge, which they then practise with each other and on simulated patients, before attending a clinical attachment where they both observe clinicians demonstrating the skills, and practise by interacting with patients themselves.

• “…Even better would be to use real patients. For example, incorporate one afternoon with a GP taking social histories from their patients. This would provide variety, real life experience and a chance to practise the skills we learnt.” (student 1996)
• "Good practice for putting everything into practice. However real patients would be preferable as broader range of subject topics would be covered and not just those that are in the script." (student 1996)

• "...more ongoing contact with patients and ongoing assessment would be good." (student 1996)

Aboriginal simulated patients

Indigenous health issues are given a greater profile in the new medical curriculum, in keeping with the priorities of health care delivery in Australia. The author is currently involved with others in establishing a pool of Aboriginal simulated patients. There has been much enthusiasm among Aboriginal actors so far, and funding sources are being explored. As well as involving these simulated patients in programs specifically dealing with indigenous health, it is also planned to include these actors among the regular teaching pool, such as in the third / first year communications skills course, and the fifth year General Practice rotation. Although representatives of the Aboriginal community will work with the course co-ordinators to develop the specific cultural issues within the cases, the presentations themselves will continue to be common to general practice, and not signposted as "Indigenous health". Thus, the students will have the complex issues of health care for Aborigines, such as access, reinforced throughout different programs of the course, as well as crystallising the importance of patient-centred skills to explore the beliefs, fears, expectations and background of all their patients.
Standardized Patients

There has been some interest within the Medical Faculty to develop a pool of real patients, who have been trained to present their illnesses in a standardized way. This will have particular benefits for the teaching of physical examination, if the patients have physical signs which the students need to learn to detect. Alternatively, simulated patients can be trained to “mimic” physical signs. Barrows in particular has detailed his experiences in this area, which is how he first became interested in simulated patients, and he claims success in a surprisingly broad range of abnormalities [50].

The GAPP Project

The author is a co-investigator in the GAPP (Guide-lines for Assessing Postnatal Problems) project, which is a multifaceted educational program for general practitioners. It is an arm of PRISM (Program of Resources, Information and Support for Mothers), which, in turn, is a community intervention trial which aims to improve the physical and emotional health of women following childbirth through an integrated program of primary care and community based strategies. The intervention, including the general practitioner training, will be provided to eight randomised municipalities, which will then be compared to eight control municipalities. The GAPP Research Team is based at the University of Melbourne, and are in collaboration with the PRISM Team from the Centre for the Study of Mothers’ and Children’s Health at La Trobe University.
Simulated patients are used in the GAPP program to visit participating general practitioners in their clinics. They are identified to the doctors, and undertake a consultation with them, portraying a woman presenting with common postnatal difficulties. The simulated patients complete a written evaluation of the consultation using a check-list, then return to the doctor for a one-to-one feedback session. These visits occur twice - pre- and post-intervention, with the same patient re-presenting to the doctor on the second visit, 6 months down the track, and with different issues to consider. The outcomes of the written evaluation will be analysed for change in the doctors' consulting skills.

Thirty hours was spent in training this pool of simulated patients, some of whom had also worked with the medical students. Time was spent in case development, ensuring standardization of presentation; training the simulated patients to give feedback one-to-one; and in ensuring standardization and refinement of the written evaluation.

Simulated patients are also used in Workshop 2 of the program, which occurs after the first visit and a clinical audit undertaken by the general practitioners. This workshop has two main sessions: introducing the doctors to the use of systematic evidence-based guide-lines for post-natal care, and a session run by a clinical psychologist (or the author) on Active Listening. Simulated patients are used in this second session in a “fishbowl”. In this approach, the facilitator works with a group of approximately 6 doctors, who sit around a central area, in
which one of the doctors consults with the simulated patient in role. The facilitator stops and starts the consultation, to enable the group to analyse the process, and for the simulated patient and consulting doctor to comment on the progress and their reasoning and emotional reactions. Alternative approaches to the consultation are discussed and the doctors step into and out of the position of the consulting general practitioner, to try out these different skills. This session requires the patient to be able to stop and start the role-play, provide immediate feedback on the patient’s feelings and responses, and respond with authenticity to a “tag team” of different doctors undertaking the same consultation, but with different approaches.

The same pool of simulated patients were also used in similar workshops for Child and Maternal Health nurses in the intervention municipalities.
Chapter 6: Potential Future Developments

Pre- and Post-course videotaped interview

Some of the students suggested that they would have found it valuable to have undertaken a videotaped interview with a simulated patient prior to the Communication Skills course.

- "It would be interesting to see whether one would see an improvement in skills after the tutes (i.e. tape in 1st session and last session and compare skills employed)." (student 1996)
- "I think it would have been good to do a video before we started and see what, if anything, had changed in your approach, because I think personally like my style hasn’t changed but I am sure the way I thought about things would have made a difference and for some other people it might have made a difference to the way they approached the whole thing" (student 1995)

There is some educational merit in this suggestion. The evaluation has suggested that the videotaped interview heightened students awareness of the importance of communication in medical practice, as well as raising their self-awareness of their own skills level. It could be argued that the students would therefore approach the whole course with a different agenda and frame of mind. Adult educational theory stresses the importance of undertaking a needs assessment
prior to an educational program, and a videotaped interview / debriefing could provide invaluable information for the course design and content.

Marteau et al. in particular has argued that a pre-course video would be beneficial and enhance the training [4]. Their argument is based on their finding that medical students self-assessment of their communication skills were poor, and there was, in fact, an inverse relationship, if any, between confidence and skill level, particularly in verbal and non-verbal facilitation and the ability to detect verbal and non-verbal cues from the patient. They therefore suggest that the confident, but poorly skilled student will be poorly motivated to participate and learn from training, and they may benefit from detailed, video feedback prior to the course. [4]

However, it is not clear whether the training sensitizes the students to this process. The mutual trust which is necessary for self disclosure and which develops over the course of the tutorials between the students, their peers and the tutors may also be a prerequisite for the students to capitalise on the experience. The effect of the introduction of a pre-course video would have to be evaluated if the suggestion were put in place.

A series of video-taped interviews

It is unfortunate that current financial realities limit the students to one videotaped interview with a simulated patient in the third / first year Communication Skills course, which tries to accommodate both formative and
summative assessment of core skills. Although simulated patients will be used for assessment and some teaching in other subjects in the new medical curriculum, the current third / first year course could be enhanced by a series of interviews and feedback sessions:

- "... having it at the end sort of highlights all the things you were doing wrong and it makes you aware of how much there is to learn and also when we were summing up the videos our tutor was saying: "You will get more practice, you will get more practice.", and it just sort of terrifies me that I need to have all this practice and I am about to get into the hospitals and I haven't sort of had that." (student 1995)

- "If possible have one (a simulated patient) every week, I mean I know it would pay (sic) more" (student 1995)

- "Another reason why it would be good to have them (simulated patients) throughout the tutes is that they would get a variety of different people, they could each have a different person because there is so much difference... communicating with a young woman or an older woman, it is just really different..... whether somebody can communicate with a person that talks a lot or somebody that holds back, they are going to get all different sorts." (simulated patient 1995)

There were some concerns expressed in the evaluation however, that over-use of simulated patients could be counter-productive:
• "I think you have to be very careful about over using simulated patients, I think a lot of the power and interest that they had in listening in what the person had to say was because there wasn't an overused, not perhaps an overused, but a common tool, and I thought it worked pretty well having the two sessions. They got into the swing of it with that first one in the tute sessions, it wasn't a strange thing when they actually did their assessment. It has to be very carefully balanced." (tutor 1995)

A possible solution would be for the course to include a pre-course interview as described above; one interview after each “block” of tutorials, i.e. after the block on core communication skills, and one after the block on “taboo” areas; and then one final formative / summative assessment video at the end of the course. Some students particularly expressed some frustration that they did not have the opportunity to try their skills with more complex and challenging cases, as in the “taboo” areas covered in the latter tutorials - sexuality, breaking bad news, death and dying. This is consistent with feedback from students in similar courses elsewhere [6]. It is the experience of the course co-ordinators, however, that the majority of students at this level of training need to consolidate the basic, generic skills, and that these will provide the students with the necessary foundation to deal with more emotionally charged situations. The inclusion of these areas in the tutorials of the current course serves to raise the students' sensitivity to potential difficult areas specific to medical communication; to illustrate how the generic skills are adapted to different circumstances, and simply because these issues are not adequately dealt with elsewhere in the course in a consistent
manner. Ideally, the course designers would like to include “difficult areas” in an on-going, integrated communication skills stream throughout medical training. When simulated patients have been used in more advanced communication skills courses, such as teaching medical students to break bad news, they have been rated as “the most enjoyable and useful part of the course” [17].

Some of the third year students identify other challenges in communication as well:

- “I would have liked to tackle much harder subjects like sexual experience and telling bad news. In this case, I would not like it examined, but doing these topics in tutes with other medical students is insufficient.” (student 1996)
- “An excellent idea, but 5-10 minutes isn’t really much practice for clinical school. It might be better to have more challenging circumstances presented; most of us are OK with social histories, It’s giving bad news / dealing with angry patients / asking hard questions etc. that we really need practice / advice with.” (student 1996)
- “...in our practice and in my video one, I had two young people and I think it would have been good to have someone different and perhaps even when you are doing things like breaking bad news and talking to the elderly and talking with people from different backgrounds, perhaps that would be a good chance to get people from different backgrounds even though I understand the difficulty..... but it would have been really valuable.” (student 1995)
- “when I say a difficult patient I am not talking about that they’re difficult because they’re not telling you what’s wrong with them and you have to try
and really find out what's happened and that what's difficult, I mean difficult in a more basic communication way." (student 1995)

• "...someone with different education or gender or age group, they are definitely different and then I could use the skills that I had learnt about." (student 1995)

• "In our group all the actors were older and had different backgrounds and that was much more challenging." (student 1995)

• "I found that because a lot of the students were in their 20s, maybe they could relate to your case a bit better, but my case was, I'm a man in my 40s and it's like speaking to their father in many cases and the problems that he's having, they don't quite understand......" (simulated patient 1995)

• "I found that they couldn't relate to the character that I was portraying, they really found it very difficult to relate to that age group and just as you said, they couldn't come with any kind of sympathetic attitude to what was happening in my life." (simulated patient 1995)

**Improving pass/fail reliability**

As an extension of the limitations of a one-off video-taped interview, criticism could be levelled at the current course regarding the reliability of the summative assessment, when the students are only tested with one scenario. Although, as discussed earlier in this dissertation, the literature suggests that the reliability of pass / fail decisions is high, the reliability does increase with increased numbers of cases - a minimum of two has been suggested.
It could be argued that the process of assessment of the Communication Skills course is actually a model of sequential assessment, in which all candidates undertake a short screening test. Candidates who score above a set cut-off point on the screening test automatically receive a pass on the full examination. Those who score below the cut-off point continue the examination. [35, 52] Pieters et al. asserted that assessment of an interview with a simulated patient was sensitive in detecting those candidates who perform badly in practice [65]. In the current course, students thus identified would progress to a repeat video-taped interview, debriefing session and summative assessment.

Some comfort can be taken from reiterating the consensus view of the AAMC conference that: “Reliability is less important in applications to teach and judge beginning competence (e.g. an introduction to clinical medicine course) and provide formative assessment that reinforces education. However, the normal psychometric guide-lines for reliability probably apply when a student’s academic progress or graduation is to be decided.” [44]. However, this is undeniably a concern with the current course, which demands further attention.

**A co-ordinated and integrated approach to teaching communication skills throughout the medical curriculum and beyond**

One of the weaknesses of this course is that it occurs in isolation, and is a “one-off”. For some students this will be the only formal training they will receive in
communication skills throughout their training. Some of the teaching hospital do teach communication skills, usually within medical history taking and physical examination training, but there are no attempts to link these courses, no integration of content, nor necessarily even any internal consistency of philosophy. Novack et al. found the same lack of co-ordination or sequencing throughout the curriculum in their survey of U.S. medical schools in 1991 [15]. The new medical curriculum at the University of Melbourne will go some way towards resolving this, to achieving a co-ordinated approach to communication skills teaching throughout the undergraduate training, because of increased integration between semesters and across Departments. Ideally this will further extend through residency training in the various specialties - including general practice, and even into Continuing Medical Education Programs, of which the GAPP Program is a prime example.

Whatever formal teaching occurs, however, the knowledge, skills and attitudes of good communication in medical practice need to be mirrored and reinforced by the role models, and the "hidden curriculum" of the medical community. Twenty years ago it was suggested that clinical teachers undermine the formal teaching of interpersonal skills, by emphasising the need for a quick history with a focus on the physical aspects of a patient's symptoms [3]. One could wonder how much this has changed, if at all.

In most medical schools around the world there has been a tendency to allocate communication skills training to Departments of General Practice, Family
Medicine or Psychiatry. It can appear to students that communication skills are therefore important for these disciplines, but of little concern to the other specialties. Marteau et al. demonstrated that as early as the first clinical year, career preference was a direct indicator as to how relevant the students rated communication skills to medical practice [4]. There needs to be a unified, integrated and consistent approach to teaching interpersonal skills across all disciplines, if students are to appreciate their fundamental importance to all forms of medical practice. [6, 15]
Chapter 7: Conclusions

This dissertation describes the introduction of simulated patients to the Communication Skills course for third year medical students, including qualitative evaluation from the first 2 years experience, and sets this in the context of the body of literature on the use of simulated patients in medical education since their introduction in 1962. Developments in the use of simulated patients based on the experience of their use in the Communication Skills course are described.

Based on the literature, the course takes an experiential approach to the teaching of core communication skills, which emphasises performance over theory, and aims to increase students’ self-awareness of their own communication and their understanding of the importance of interpersonal skills to medical practice. The assessment, while formal, is educational and remedial, and actively involves the students.

The evaluation has demonstrated that the introduction of simulated patients represented an improvement and enrichment in the teaching of communication skills in the third year course. The basis for this conclusion is that:

- Simulated patients improved the verisimilitude of role-play interviews compared with student-as-patient role-plays.

Although there were some concerns raised about the unreality of the setting and learning to take a structured history, the comments from students and tutors
overwhelmingly supported the realism of interviews with simulated patients compared to role-plays with fellow students.

- **Simulated patients provide ethical and educational process advantages over other experiential methods such as real patients.**

By interviewing simulated patients as a “stepping stone” to their contact with real patients, students were grateful to be able to practise the skills - and therefore make mistakes - in a relatively safe environment. There are also not the ethical concerns of video-taping interviews with simulated patients, as there would be with real patients. Students thus have the opportunity to observe their own performance, which they felt was a highly valuable learning experience. Using simulated patients also offered the course co-ordinators the advantage of availability, with an educational method that has been shown to be reliable and valid in numerous studies cited in the literature.

- **Experiential methods such as simulated patients provide a better match between learning objectives and teaching / assessment methods, by bridging the gap between competence and performance.**

A course on process skills requires a method of teaching and assessment that focuses on performance, not just knowledge. Comments from tutors and students demonstrated an awareness of this gap, and the need for students to progress from theoretical competence to mastery of the application of skills.
• The use of simulated patients provides Faculty with an opportunity for increased control over case content and standards for performance.

The introduction of simulated patients allowed the course co-ordinators to develop cases of a standardized complexity and which reflected the focus of the course on interpersonal skills rather than knowledge of medical content. The actors were also trained to portray each patient in a standardized, yet responsive manner, allowing for comparison between students’ interviews. Thus the summative assessment component of the course was more rigorous than prior to the use of simulated patients, although more work needs to be done on this area.

• The inclusion of videotaped interviews and debriefing with a simulated patient resulted in an increase in students’ awareness of the importance and range of communication skills in medical practice.

The tutors, in particular, commented that the introduction of simulated patients “transformed” the students’ understanding of the importance of communication skills. They approached the assessment task much more seriously, and as methods of assessment send strong messages to students about the importance of what is to be learned, they also approached the learning of communication skills more seriously. Observation of their own and others’ interviews and feedback from the simulated patients all reinforced the importance of effective communication, and increased the students’ exposure to different communication approaches.
• *The introduction of simulated patients provides access to a range of new learning opportunities such as observation between peers; feedback from (simulated) patients and rehearsal of specific skills.*

As well as improving the rigour of the summative assessment of the course, using simulated patients opened up opportunities for powerful formative assessment processes. Students were able to observe and analyse the impact of different communication approaches on an interview, and they, and the tutors, reported that this was helpful. They received direct feedback from the simulators, which they perceived as credible, and there was the possibility to resume the interview to try out different approaches, although this was quite challenging to some of the simulated patients.

Since the establishment of a pool of simulated patients for the third year Communication Skills course, their potential has been developed in a wide range of educational applications. These include involving them in the teaching and assessment of diagnostic and management processes for fifth year medical students and increasing students’ exposure to simulated patients in the teaching and assessment of process skills throughout the new medical curriculum. A pool of Aboriginal simulated patients is being established, and the development of a standardized patients pool for the teaching of physical examination skills is under consideration. Simulated patients have also been used in a research project as both an educational intervention and as a means of evaluating the effect of a specific training program for general practitioners.
Areas of possible future development and evaluation include modifying the current third / first year Communication Skills course to include a series of videotaped interviews and debriefing sessions with simulated patients, perhaps commencing with a video-taped interview as a needs assessment process prior to commencing the training. The reliability of the summative assessment of the course would be increased by increasing the number of cases per student in the examination - to a minimum of two.

Finally, the teaching of communication skills, including the use of simulated patients, would benefit from integration and reinforcement throughout the medical curriculum and beyond into post-graduate training and continuing medical education. As one of the simulated patients said, when asked why they were involved in the program: "Communication is important."
Appendix 1

LEARNER-CENTRED FEEDBACK

There are two common models of teaching - the transmission model and the dialogue or Socratic model. The former is the one with which medical students are traditionally most familiar. In this model, "teaching is telling, and learning is listening" (Stewart et al, 1995 p.118). The student is perceived as the passive recipient of knowledge from the teacher.

An important aim of the video session is that students are required to demonstrate the application of communication. Donald Schon, in his books The Reflective Practitioner and Educating the Reflective Practitioner pointed out that "Students can only learn to be professionals by doing, but they do not yet know how to do it, and the task itself is too complex to describe fully in words." Thus the transmission model is insufficient by itself to enable students to develop the necessary skills.

The Communication Skills tutorials, and particularly the video debriefing sessions, follow the dialogue or conversation model in which tutors and learners are "inquirers, helping one another in the shared pursuit of the truth". This is not to deny that there is an inherent imbalance in knowledge and experience between the tutor and learner. Rather it recognizes that students are not without any previous knowledge and experience. The tutor helps the students identify, develop and practise the generic clinical skills, which they will then be able to apply effectively and expand upon in a wide range of circumstances. The interaction with the simulated patient provides the student with an opportunity "to experience the need to know". The aim of the tutorials is to achieve all this, through a learner-centred approach.

The learner-centred approach is a parallel model to the patient-centred approach to clinical practice which is reflected in the Communication Skills course, and later taught formally to students in their clinical years. It consists of six interactive components:

1. Exploring learning needs and aspirations
2. Understanding the whole person
3. Finding common ground
4. Incorporating prior knowledge
5. Enhancing the teacher-learner relationship
6. Being realistic

These processes will develop over the course of the tutorials, which is the main reason we put a high priority on maintaining continuity within the tutorial group. The video debriefing session is then based on the mutual understanding and trust that we hope develops within the group over the tutorials.
The feedback should, however, still be challenging, and provide students with insights. One of the major skills for the tutor is to achieve an appropriate balance between challenging and supporting the learners (see table below). Provide the students with the opportunity to challenge different ways of thinking, to try out their understandings and explore contradictions.

<table>
<thead>
<tr>
<th>Support</th>
<th>Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>high</td>
</tr>
<tr>
<td></td>
<td>low</td>
</tr>
<tr>
<td>high</td>
<td>Growth and</td>
</tr>
<tr>
<td></td>
<td>Motivation</td>
</tr>
<tr>
<td>low</td>
<td>Retreat</td>
</tr>
<tr>
<td></td>
<td>Stasis</td>
</tr>
</tbody>
</table>

**Table 1.1** Framework of the tasks of Mentors.

There are a number of principles in providing feedback to achieve these aims:

**Characteristics of Effective Feedback**

Feedback is the communication of information about performance, and has been shown to be effective in motivating and facilitating behaviour change.

Feedback should be **descriptive**, rather than evaluative or judgemental - for example: "I noticed you avoided eye contact with the patient" versus "You are rather weak in interviewing skills".

Feedback should be **specific**, rather than general - for example: "You explored the facts about the patient’s difficulties with the law in a lot of detail, but seemed uncertain how to explore his feelings about this and the effect on his family" versus "You’ll become more comfortable dealing with people’s emotions with more experience". Use direct quotes from the interview, or stop the video at relevant points to illustrate particular issues.

Feedback should focus on **behaviour**, rather than on assuming personality traits - for example: "The frequent use of open-ended questions, silence and other responding skills demonstrated your interest and allowed the patient to tell you what’s on her mind" versus "You are warm and caring towards your patients".

Feedback involves **sharing information**, rather than on giving advice. Encourage learners to decide for themselves how to handle the problem.

Feedback should be **limited** to the amount of information learners can absorb at the time, rather than overload them. Feedback should therefore be **incomplete**, to encourage students to reflect further on the issues.

Feedback should be **to the point**, so that the messages are clear and unambiguous.

Feedback should be **verified or checked** with learners - for example - "How do you
think the interview went?"....."This is what I observed, does that match how you thought it went?".

The tutor should pay attention to the consequences of feedback - the verbal and non-verbal responses of students noted. Students should be encouraged to comment and expand on the feedback.

If the feedback is corrective, the learner must be given the opportunity to explore alternatives.

Avoid collusion: while brutally frank feedback may be harmful, avoid misleading, meaningless or dishonest feedback - for example: "That was okay".

These characteristics are as true for positive feedback as for feedback which focuses on ineffective interactions.

Based on: Table 11.2 Stewart et al. 1995 p150

The process of giving feedback requires the same communication skills that form the basis of the course. Tutors should model, in their interactions with students, the quality of interpersonal communication we expect our students to demonstrate with patients.

Some models of giving feedback suggest giving positive feedback before giving negative feedback. Another approach is to ask the student to comment on their own consultation first, and discuss the issues that they raise, before broadening the feedback discussion to cover issues that they haven't identified. This is similar to the exchange in a typical medical consultation - we allow the patient to describe their perceptions and experiences first, then use interviewing skills to elaborate / probe certain issues and introduce new issues. The student is likely to be critical of their performance and comment on the less effective aspects of the interview first. By following their lead you can "clear the air" of these issues, and the students will be more receptive when you then move on to reinforce the more effective aspects.

Establish a pattern of constructive feedback, for example -
"How could this have been done more effectively?"
"What made this response effective?"
"How could this have been done differently?"

One of the less overt objectives of the video debriefing session, and indeed the whole course, is that students begin to develop the practice of self-assessment and reflection on performance, and use intrinsic feedback in the consultation.

References:


Kathryn Robertson Aug 1996
Appendix 2

INTERVIEW EVALUATION FORM.

1. ATTENDING SKILLS

<table>
<thead>
<tr>
<th>SKILL</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintained eye contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed open posture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable distance and angle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open and receptive facial expression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ATTENDING BEHAVIOUR CHECK-LIST (Please tick the appropriate box)

2. DIRECTING SKILLS

<table>
<thead>
<tr>
<th>SKILL</th>
<th>USE</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>Under Use</td>
</tr>
<tr>
<td>Open-ended questions</td>
<td></td>
</tr>
<tr>
<td>Focused questions</td>
<td></td>
</tr>
<tr>
<td>Closed questions</td>
<td></td>
</tr>
</tbody>
</table>

QUESTIONING SKILLS CHECK-LIST (Please tick the appropriate box)

3. FOLLOWING SKILLS

<table>
<thead>
<tr>
<th>SKILL</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under Use</td>
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<tr>
<td></td>
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### FOLLOWING SKILLS CHECK-LIST (Please tick the appropriate box)

<table>
<thead>
<tr>
<th>SKILL</th>
<th>USE</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>Clarification</td>
<td></td>
</tr>
<tr>
<td>Confirmation</td>
<td></td>
</tr>
<tr>
<td>Minimal non-verbal encouragers</td>
<td></td>
</tr>
<tr>
<td>Minimal verbal encouragers</td>
<td></td>
</tr>
<tr>
<td>Probes</td>
<td></td>
</tr>
<tr>
<td>Attentive silence</td>
<td></td>
</tr>
</tbody>
</table>

### 4. REFLECTING SKILLS

### REFLECTING SKILLS CHECK-LIST (Please tick the appropriate box)

<table>
<thead>
<tr>
<th>SKILL</th>
<th>USE</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
<tr>
<td>Paraphrasing</td>
<td></td>
</tr>
<tr>
<td>Reflecting feelings</td>
<td></td>
</tr>
<tr>
<td>Restatement</td>
<td></td>
</tr>
<tr>
<td>Summarising</td>
<td></td>
</tr>
</tbody>
</table>

### 5. INTEGRATION OF THE INTERVIEW

### 6. OTHER COMMENTS
Appendix 3

GUIDE FOR SIMULATED PATIENTS WORKING IN
COMMUNICATION SKILLS - THIRD YEAR MEDICINE
1996

1. Structure of the course
The aim of the course is to teach students the basic concepts of effective
communication and interviewing skills. The course consists of an introductory
lecture and nine x one hour weekly tutorials. The tutorials are designed to
courage students to practise and consolidate their communication and
interviewing skills though role-play and discussion.

At the end of the course, each student is required to make a video-tape of an
interview with a simulated patient and attend a video debriefing session. In the
interview, students are required to take a social history and the interviews are
expected to be between seven and ten minutes long. In taking a social history,
students are expected to collect information such as age, marital status, details of
the patient’s family structure, supportive network, employment, living situation,
leisure activities, significant life events and sources of life stress. As they are
only third year students and have not yet begun their clinical training, they are
not expected to collect medical information, provide medical advice or
counselling.

Simulated patients are used in the final tutorials and in the video-making and
debriefing sessions.

2. Video making and debriefing
The video-making and debriefing sessions occur in the last three weeks of the
semester (the weeks beginning 7/10; 14/10 and 21/10). A video station is set up
for each tutorial group and each week four students from each group are required
to make their video-taped interviews with a simulated patient. Each session is
three hours long. In the first hour the students make their video-tapes (15
minutes per student). The four students, the simulated patients and the tutor then
participate in a two hour debriefing session in which the video-taped interviews
are presented and feedback is given.

The tutor will direct the debriefing session and you will be called on to give
feedback in role as the patient. The tutors have worked with their group of
students over a number of weeks and they understand the standard we expect of
third year students. Therefore they may choose not to respond to something that
may seem to be a glaring mistake to you. Remember that you are participating in
a “snapshot” from the ongoing relationship between tutor and students, and the
students and their six years of training to become a doctor.

Simulated patients who have already worked with fifth year students will
probably notice the difference in the medical knowledge and interviewing skills
of the two groups. Remember these are third year students. **Please do not expect them to perform at the same level as the fifth years students.**

We have a very tight schedule for the video-making and debriefing. Therefore it is imperative that simulated patients are reliable and arrive on time.

3. **Skills required of the simulated patient**
   a) **Responsiveness to students**
   Remember you are not the star of this performance! The purpose of the exercise is to provide students with the opportunity to practise and receive feedback about their interviewing skills. Thus it is important that you play your role in a way which is responsive to each student’s communication style. For example, you are expected to be responsive to students who are empathic and / or good listeners, and less responsive to students who are blunt or disinterested. Students who ask open-ended questions will elicit more information than those who ask a checklist of closed questions.

   b) **Inner reflection**
   In the debriefing you will be required to give feedback to the students in role as the patient. You will be asked how you responded emotionally to the student’s interviewing style and to questions and responses given during the course of the interview. Thus you need to be able to reflect on your feelings during the interview.

   c) **Ability to provide constructive and responsive feedback**
   In the role of the patient you will have important feedback for the students. It is important that this relates to their interviewing style and that it is presented constructively. Avoid feedback which is judgemental, ambiguous or involves giving advice.

   d) **Ability to take on a role and improvise**
   Each week you will play the same patient role for the four students you work with. Your role will include basic details of family and social background for the patient you are playing and you will be required to use this information to develop the role. You will need to improvise when students ask you more detailed information than is provided in your brief. Remember it is important that your presentation of the role and improvisation is consistent across the four interviews.

4. **Guide-lines for giving feedback as a simulated patient**
   The following list of questions is designed to help you focus on the sort of information which is likely to be discussed during the feedback session -

   - What are your predominant feelings about the interview?
   - Did you feel comfortable discussing your personal issues with this student?
   - Were you given the opportunity to discuss the issues that are important to you?
   - How did it feel when you were / weren’t given this opportunity?
   - Did you feel listened to?
• Note the particular times when you felt (or didn’t feel) listened to.
• How did it feel when you were / weren’t listened to?
• Do you think that the interviewer understood how you felt?
Appendix 4

Student Focus Group 1995
Questioning Route

Welcome and introduction to focus group process

Introductory Question: Tell us your first name and any future career plans at this stage.

1. What were your expectations of the Communication Skills course prior to starting?

2. Were these expectations met?

3. What were the most significant things you got out of the course?

4. Focussing specifically on the introduction of simulated patients: - any general comments?

5. What were the differences in using simulated patients or fellow students for role-play?

6. Any comments about the structure of the video-taping and debriefing sessions?

7. How useful was it to see other students' interviews with the same patient?

8. How useful was the feedback from the simulated patient?

9. Any further comments on the process overall?

10. Any suggestions for improvements?

Summarise issues raised

11. Is this an adequate summary?

Outline purpose of study

12. Have we missed anything?

(NB. Use phrases such as "Are there any other points of view" to explore diversity of opinion.)
Appendix 5

Tutor Focus Groups 1995
Questioning Route

Welcome and introduction to focus group process.

Introductory Question: Introduce yourself by your first name, and outline your background of involvement in the 3rd year Communication Skills course.

1. Any comments on the process overall?

2. What would you identify as the goals for the course overall?

3. Did you feel these were met?

4. Focussing specifically on the introduction of simulated patients - any general comments?

5. What were the differences in using simulated patients and students in role plays?

6. Any comments about the structure of the videotaping and debriefing sessions?

7. How useful was it to have the students interviewing the same patients?

8. How useful was the feedback from the simulated patients?

9. Any further comments on the process overall?

10. Any suggestions for improvements?

Summarise issues raised.

11. Is this an adequate summary?

Outline purpose of the study.

12. Have we missed anything?
Appendix 6

Simulated Patient Focus Group 1995
Questioning Route

Welcome and introduction to focus group process.

Introductory Question: Introduce yourself by your first name, and describe briefly your background experience, or how you came to be involved in this program.

1. What were your reasons for becoming involved in the simulated patient program?

2. Do you feel that these were fulfilled?

3. Were the role-plays realistic?

4. Any comments about the structure of the video-taping sessions?

5. Any comments about the feedback session?

6. Any comments about the training you received?

7. Any further comments?

8. Any suggestions for improvement?

Summarise issues raised.

9. Is this an adequate summary?

Outline purpose of study.

10. Have we missed anything?
Appendix 7

DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE

Third year Medicine Communication Skills Course 1996

Student Feedback Questionnaire

1. Please circle your tutor:
   - Tim Barajewski
   - Liz Davies
   - Mary-Anne Hope
   - Natasha Lancaster
   - Marie Pirotta
   - Robyn Vafiadis
   - Patrick Campesi
   - Denise Findlay
   - David Horne
   - Heather McCormack
   - Vani Reddi
   - Amanda Wright
   - Michael Carr-Gregg
   - John Furler
   - Georgia Karabatsos
   - Wendy O'Connor
   - Kathryn Robertson

2. Quality of teaching:

<table>
<thead>
<tr>
<th>Poor</th>
<th>Marginal</th>
<th>Average</th>
<th>Fairly Good</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Comments:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

3. Please rate the individual tutorial topics for their interest and relevance using the following scale:

<table>
<thead>
<tr>
<th>No interest or relevance</th>
<th>Marginal</th>
<th>Moderate</th>
<th>Reasonable</th>
<th>Highly interesting and relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

INTRODUCTION TO COMMUNICATION SKILLS

- Listening and Responding Skills I and II
- Influences and Interactions in Communication
- Communication across Differences

BREAKING THE TABOOS

- Communicating with patients when discussing sexual issues
- Communicating bad news
• Receiving bad news - the patient’s perspective (seminar format) 1 2 3 4 5
• Death and Dying 1 2 3 4 5

TAKING A SOCIAL HISTORY

• Taking a social history - putting it all together 1 2 3 4 5

4. Please comment on the following specific aspects of the course:

The duration of the tutorials for the material covered:

________________________________________________________________________

________________________________________________________________________

The value, or otherwise, of hearing the patients’ perspectives on receiving bad news:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

The use of simulated patients:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other comments:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you for taking the time to fill out this questionnaire. The information you have provided will be used when reviewing this course and planning future courses.

HOW TO RETURN THIS QUESTIONNAIRE:
A: Put in box at front desk of PH&CM at 200 Berkeley Street, Carlton
or
B: Give to Steve Farish in the PH&CM lecture(s)
Appendix 8

Topic Guide for 1996 Focus Group with Tutors

The length of the tutorials for the amount of material to be covered.
Did you feel you were rushing through?
If you dropped material, how did you decide what to drop?
Should the tutorials be extended to one and a half hours?

Content
Are the topics appropriate?
Is there any topic that should be deleted / added?

Structure of the tutorials.
e.g. specific exercises, role plays and group discussions?

Tutor Notes.
Were they helpful?
How could they be improved?

(XX From here are the things Kathryn is most interested in)

Videotaped and debriefing sessions
How did it go?
Any thing different?

Simulated patients.
How did it go?
Any thing different?
Were the roles useful / appropriate?
Were you satisfied with the feedback from the simulated patients?

Pre-tutorial tutors meetings.
If you attended, did you find it useful?
In what ways, what could be improved?

The course overall.
Bibliography


Author/s: ROBERTSON, KATHRYN

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Date: 1999

Citation: Robertson, K. (1999). "It really felt real": the introduction of simulated patients to the Communication Skills Course for third year medical students at the University of Melbourne. Masters Research thesis, Faculty of Education, The University of Melbourne.

Publication Status: Unpublished

Persistent Link: http://hdl.handle.net/11343/39382

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