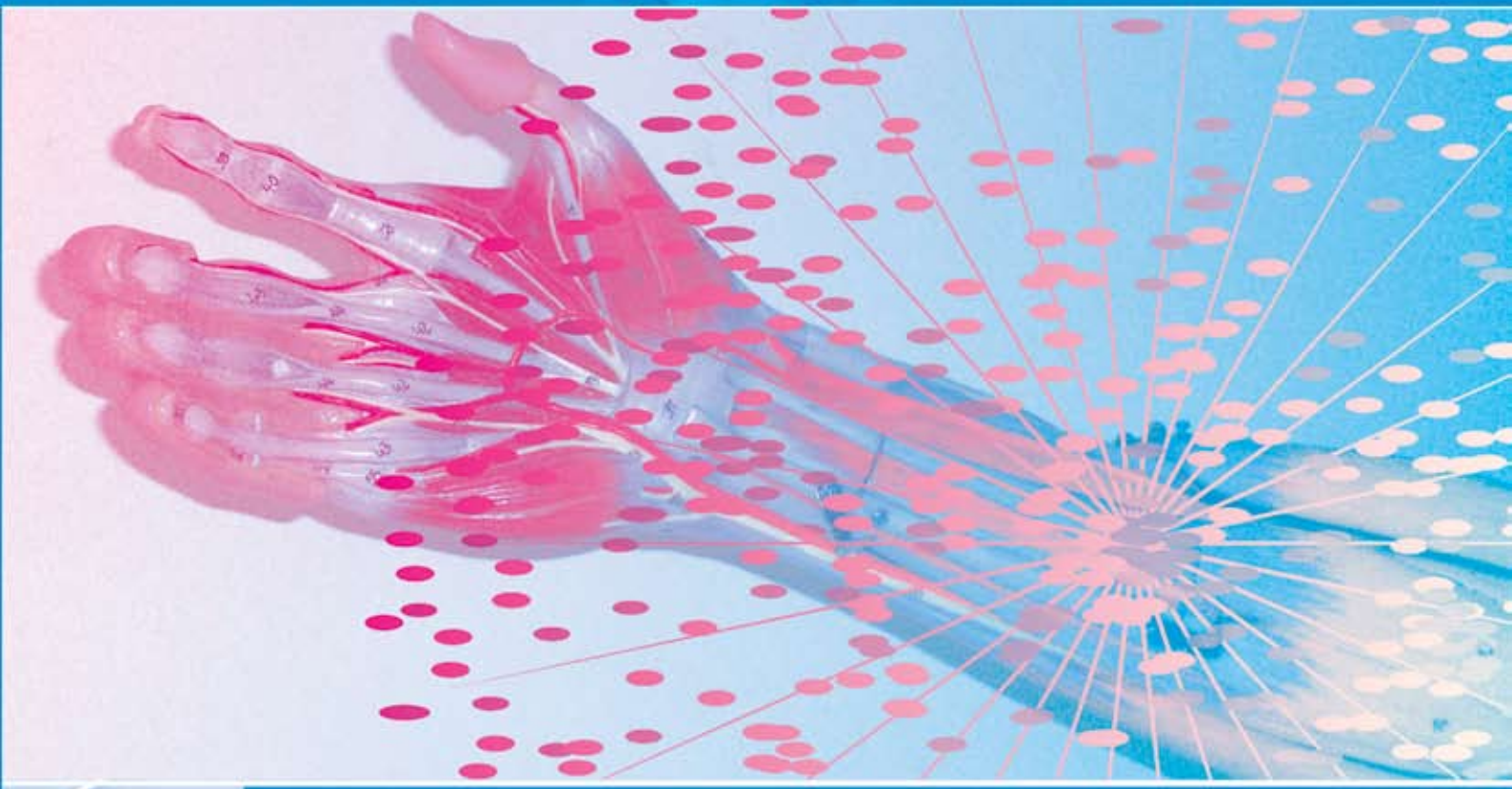
ISSN 1753-044X

Volume 2 Issue 2
September 2008

INTERNATIONAL JOURNAL OF CLINICAL SKILLS



A Peer Reviewed International Journal for the Advancement of Clinical Skills
- 'docendo ac discendo' - 'by teaching and learning'

In this issue:

Simulating haemorrhage in medical students
The i-DREAM Project
Educational leadership: a core clinical teaching skill?
Designing a clinical skills programme…
Learning to talk with patients

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Published by SkillsClinic Ltd.

Acknowledgements

I would like to take this opportunity to show appreciation to all those involved with the production of the International Journal of Clinical Skills. Many thanks to all the members of the Editorial and Executive Boards. Special thanks to Dr M. Selvaratnam and Mark Chapman for their kind support. Also a generous thank you to Tina Wilkin for her invaluable creativity.

The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

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Foreword

Globalisation and Clinical Skills

The International Journal of Clinical Skills (IJOCS) – the new road to new skills? Maybe – but it has certainly opened a platform for the globalisation of clinical skills. The World Health Organisation's (WHO) programme on globalisation targets public health risks, security and outcomes. Driven by the concept of "global public goods" and cross-border health risks, the underpinning issue is to promote health for the poor by way of achieving national health targets. As with the IJOCS, the WHO strategy seeks new technologies in the clinical arena to provide investigative tests – with the WHO being particularly interested in those tests which are suitable for developing countries along with new drugs for endemic diseases. The aims are indeed noble. Investigative and therapeutic technologies create a vacuum for the dissemination, sharing and globalisation of clinical skills, which remain the main asset and commodity which clinicians of poorer nations exercise, promote and share. The IJOCS has released a bolt for health professionals to do just that – share knowledge.

The provisions of the healthcare industry in developed countries by sheer volume and demand, streamlines clinical skills into sub-specialised areas. Clinicians (medical, paramedical and nursing) in these areas gain clinical expertise that are unique to their field and emerge from rich patient-clinician interactions. The clinical skills of dealing with children with disabilities, rehabilitation medicine and terminal care are mere examples that are deficient in the poorer health economies that spend the best part of their human resources to combat diseases of malnutrition and poor sanitation.

The IJOCS provides a global resource centre for sharing and promoting clinical skills between clinicians and health professionals. Senior clinicians, who practiced medicine during the last four decades, will have recognised a gradual and progressive pattern of dependence on technologies with less reliance on clinical skills. The IJOCS provides a platform for sharing and debating the inter-phase and interactions between new technologies and clinical skills. It promotes the development of a new layer of clinical expertise that will emerge from the interpretation, application and/or exclusion of new technologies, for the benefit of clinical care.

I trust that clinicians practicing in poorer health economies will enhance the Journal by sharing their clinical skills and knowledge. Their special expertise of managing clinical needs, within restricted resources, expectedly stimulates the human ingenuity and creativity, leading to the development of clinical skills suitable for each unique circumstance. I, for one, will be actively supporting the IJOCS innovative approach to collaboration of skills. The IJOCS will provide a vehicle for the transmission of these skills across the globe for sharing expertise between different health economies to enrich the overall clinical skills arena.

Hippocrates recognised the professional responsibility of the individual clinician by stating that physicians "must have a wealthy …medical knowledge, clinical skills, medical ethics, interpersonal skills,…". The IJOCS improves the physician's opportunity to enhance his/her clinical skills "by teaching and learning".

Dr Atef R Markos FRCOG FRCP

Learning to talk with patients: feasibility of a volunteer simulated patient programme for first-year medical students

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KEYWORDS:
Communication skills
Simulated patients
Community involvement

Abstract

BACKGROUND: Medical educators have the challenge of providing learner-centred education in patient-centred environments. Simulation provides an acceptable alternative to meeting students needs while not compromising those of patients. Professional actors contribute extensively to teaching and assessment of communication and other professional skills but are a relatively expensive resource. We wanted to provide our first-year students with a safe and effective means of developing communication skills relevant to interacting with patients. METHODS: We developed a simulated patient programme using volunteers to provide students with an opportunity to interview and receive feedback from members of our local community. This paper describes the development of the programme and evaluates its feasibility. We used observations, questionnaires and focus group interviews in the evaluation that included students, volunteer simulated patients and faculty. RESULTS: The results showed that the session is feasible and can be delivered with minimal additional costs although it requires careful planning. All participants rated the experience positively with benefits identified for students and volunteers. Areas for development include an elaborated role proforma to support volunteers in planning their patient role, and a more discriminating and extended feedback rating form for volunteers to assess students' patient-centred communication skills. CONCLUSION: Our feasibility study identified strengths of the programme and areas for development. Both students and Volunteer Simulated Patients (VSPs) reported benefits. The programme enabled lay members of our community to make a meaningful contribution to undergraduate medical education by providing experiential learning opportunities for novice students.

Background

The General Medical Council (GMC) in the United Kingdom (UK) expects new doctors to be able to communicate sensitively and effectively with patients and their relatives [1]. Communication skills are widely taught in medical schools in the UK [2,3]. Various educational methods are used that include approaches to ensure the transmission of knowledge, attitudes commensurate with patient-centred interviewing as well as opportunities to rehearse and receive feedback on skills.

In some circumstances it is ethically appropriate for students to rehearse using simulation before working with real patients. Simulated (or standardised) patients (SPs) are individuals trained to portray real patients [4]. SPs are well established in medical education for teaching and assessing communication skills [5,6,7]. SPs have the advantage of providing a 'safe' learning environment, adjustable level of challenge and reproducible learning experiences. SPs can also provide students with focused and immediate feedback that is often difficult or compromising for real patients to deliver.

At our medical school, first-year students participate in five communication sessions covering a range of topics that use various educational methods (Figure 1). In previous cohorts,

students have rated highly the educational value of interviews with SPs. We use simulation to provide students with the opportunity to practice basic interviewing skills and to receive feedback from patients. The educational theory underpinning this approach draws on experiential learning theory [8], adult learning theory [9] and reflective practice [10].

Figure 1: Communication programme in year 1

Topics:	• Evidence for patient-centred interviewing • Skills for communicating with patients > Non-verbal / Verbal • Giving and receiving feedback • Making presentations
Educational methods:	• Lectures • Readings • Small group discussions • Role-play – observing, interviewing, facilitating feedback • Interviews with simulated patients – professional actors and volunteers • Videotape review • Written reflections
Session titles:	1. Consultation skills – the initial approach 2. Non-verbal communication and presentation skills 3. Patient centred communication – using role-play 4. Interviewing simulated patients I (volunteer simulated patients) 5. Interviewing simulated patients – II (professional actors as simulated patients)

SP sessions are highly resource intensive and at our London medical school costs approximately £5,000 per cohort of 360 students for each student to interview a professional SP (an actor trained to portray a specific patient role). We wanted to find additional and cost-effective ways of providing students with multiple interviewing opportunities including ways to receive feedback on their performance.

The GMC is also promoting user-involvement in medical education and seeking ways to engage real patients and the lay population in curricula activities [11]. Given the relatively high cost of professional actors and the growing need for lay involvement in medical education, we developed a Volunteer Simulated Patient (VSP) programme. We invited our local well population to act as VSPs in simulations focused on basic patient-centred communication. Although volunteers are reportedly used in communication training there is little empirically based information in the medical education literature documenting recruitment and training processes for such programmes [12].

Our principal research question is:
To what extent is a VSP programme feasible in supporting the development of communication skills in novice medical students?

Multiple perspectives are important in feasibility studies so we obtained feedback from student, VSP and faculty participants. Specifically, we hypothesised that after students have interviewed VSPs, students would have increased confidence and competence in relation to approaching patients. We anticipated that there would be benefits to VSPs such as increased insight, access and contribution to medical education, greater confidence about and raised awareness of basic medical interviewing skills. Finally, we anticipated potential benefits for our medical school including strengthening of relationships with our local community, increasing the local profile of our school, and that this can be achieved with minimal cost.

Methods

Description of session

In the first three sessions of the communication programme, students discussed evidence for patient-centred interviews, identified effective communication skills by viewing videotaped interviews and conducted role-plays with colleagues. In the fourth session and prior to their first four-week clinical placement, students attended this hour-long session with volunteers (Figure 1). Students were briefed by a tutor who:

- Explained the aim of the session - To provide an opportunity to practise basic interviewing skills.
- Outlined the learning objectives (Table 1).
- Gave instructions on completing the learning goals and written reflection forms.
- Reviewed the structural model to patient-centred communication we use in our communication programme (including discussion of specific skills) which formed the basis of the VSP rating form for each student.
- Clarified the student's task - Interview each patient to find out why they have come to see the doctor (a general practitioner), their ideas about the symptoms, illness and/or treatment, their concerns, their expectations of the encounter with the doctor as well as the outcome of the illness. Students were asked to inform VSPs that they were medical students and that they should seek permission to practice interviewing.

Students completed either 2 or 3 five-minute interviews depending on the number of volunteers present at the time. Learning goals and written reflection forms were completed immediately before and after each interview respectively. In the five-minute break between interviews, VSPs completed a rating form designed to reflect the communication model on which our programme is based. The VSPs immediately gave this rating form to the student who was reviewed it in the light of their own reflection and before moving to the next interview.

Volunteer simulated patients

Volunteers were recruited via leaflets, personal contacts and emails in our local community (e.g. schools, clinics and hospitals, patient liaison offices, recreational facilities, residential buildings, community fairs, shopping centres etc). Prior to the session each VSP completed a proforma designed to anticipate the types of questions students might ask (Figure 2). Volunteers were strongly encouraged to base the content of the proforma on their own experiences to authenticate the role. Proformas were not reviewed by faculty prior to the session as we wanted to minimise our involvement. On arrival, volunteers were briefed by a tutor as to the process and purpose of the session. VSPs played the same role throughout the session.

Figure 2: Proforma for volunteer simulated patient programme

Be yourself as much as possible. Think of a time when you experienced some symptoms and made a decision to go to the doctor (general practitioner - GP). Using this experience, fill out the questions below as accurately as you can. A few brief notes for each point will ensure that you have thought about the type of questions the students might ask. Please contact us if you have any questions.

Name (Do not use your own):
Why did you go to the GP? (Select a symptom or group of symptoms as your reason. E.g. back pain, flu, headaches, blood in your urine, insomnia etc. Think carefully about these and be prepared to describe them in detail if you are asked. E.g. "The pain starts right here in my temples and it just stays there for ages – for hours. It just builds up and the pressure keeps increasing. Feels like it is going to explode.")
What ideas did you have about the cause of your symptoms? (Patients usually have ideas about why they are experiencing symptoms. Be prepared to tell the student your ideas. It does not matter if they make sense or not. Doctors need to respect patient's views about their symptoms for many reasons. We are providing training that encourages students to seek out patient's ideas.)
What concerns did you have about the symptoms or any other aspect of the illness? (Again, most patients usually have some concerns. It might be anxiety about the symptoms being really serious – you might have known someone with something serious that started like this. It might be that you think you could pass it on to someone else, that it will stop you doing something you always do or that it will have a long lasting effect or lead to other conditions etc)
What were you expecting the doctor could or would do for you? (Patients are sometimes dissatisfied with their care because doctors do not do for patients what they are expecting. Although doctors cannot always do what patients want, it is important that doctors find out what patient's expectations are so they can be acknowledged and rectified. What were you expecting the doctor would do – tests, examination, prescription, reassurance etc?)
What were you expecting in relation to the outcome or your symptoms? (Think about what you were expecting would eventually happen in relation to your symptoms – would they go away by themselves, with medicine or some other treatment.)
What is your current employment? (You can make this up but it is helpful to use your own experience as much as possible. If you are in school then say you are a student) Do you enjoy your work/school?
Who do you live with? (Make up names and relationships based on your experience)
Age and date of birth (You can use your own):
Address (Do not use your own):

Evaluation methods

We used different methods to evaluate the feasibility of the session in supporting the students in learning basic skills to interact with patients.

Students

Immediately after the session, students anonymously completed rating forms indicating the degree to which they met learning objectives and the value of the different facets of the session. Before and after the session, students rated their competence and confidence in interviewing patients. Using convenience sampling, selected students participated in post-session focus group interviews (DN or TT).

Volunteer simulated patients

For the volunteers, we analysed the content of role proformas. VSPs rated each student's performance after every interview and handed this assessment to the student. Immediately after the session, VSPs completed semi-structured written evaluations exploring satisfaction with various aspects of the programme. We used convenience sampling to select volunteers to participate in focus group interviews (DN).

Faculty

Faculty recorded observations on structure and process throughout the recruitment and implementation phases of the programme.

Quantitative data were analysed using SPSS 14.0. Pre- and post-session measures of confidence and competence were tested using Wilcoxon signed rank test. Qualitative data were analysed independently (DN & TT) to identify emergent themes with topics negotiated until agreement reached.

The VSP programme was approved by our School's Curriculum Committee and carried out in accordance with Human Research Ethics guidelines. All participants (faculty, students, VSPs) were assured of anonymity, evaluation forms were de-identified, participation in interviews was voluntary and VSPs could withdraw from the programme at any time.

Results

Students

We provided all first-year medical students with the opportunity to interview either two or three volunteer patients in an hour-long session. Three hundred and forty-three students completed rating forms of whom 186 (54.2%) were female and 154 (44.9%) male. Three students (0.9%) did not record their sex.

Learning objectives

Students used a 3-point scale from not at all (1), partially (2) to completely (3) for rating the degree to which they met specified learning objectives. Table 1 shows that the learning objectives were perceived to be completely met by 167 (49.4%) to 213 (62.1%) of students. The learning objective that was completely met by the most students (62.1%) was that which related to identifying areas for development in communicating. The least well met objective was that identifying which patient-centred skills were used in the interview.

Table 1: Students' ratings of the degree to which they met learning objectives

	Not at all		Partially		Completely	
	No	%	No	%	No	%
Identify patient-centred interviewing used in the interviews	2	0.6	169	49.3	167	49.4
Identify skills that require development	6	1.7	120	35.0	210	61.2
Reflect on feedback from simulated patients	11	3.2	127	37.0	199	58.0
Develop awareness of your strengths in communicating	5	1.5	142	41.4	189	55.1
Develop awareness of your areas for development in community	6	1.7	118	34.4	213	62.1

*Missing values ranged from 4(1.2%) to 8 (2.3%)

Educational methods
Table 2 shows students' ratings of the educational methods. Interviews were rated as completely valuable by 260 (75.8%) students. The next most completely valuable method was written feedback from VSPs (n=209; 60.9%). The learning goals forms were considered least valuable (28.6%).

Table 2: Students' ratings of the value of the educational methods in meeting the learning objectives (n=343)*

	Not at all		Partially		Completely	
	No	%	No	%	No	%
Session notes	18	5.2	192	56.0	127	37.0
Learning goals	34	9.9	206	60.1	98	28.6
Interviews with simulated patients	7	2.0	71	20.7	260	75.8
Written feedback from simulated patients	19	5.5	111	32.4	209	60.9
Summary and reflection	15	4.4	197	57.4	120	35.0

*Missing values ranged from 4(1.2%) to 11 (3.2%)

VSP ratings of student performance in interviews
Complete data sets were obtained for 343 students. All students completed two interviews while 216 (63.0%) completed a third interview. Volunteers rated their satisfaction with five aspects of the interview (introduction, gathering information, warmth, empathy and closure).The mean scores were 3.3 to 3.6 (SD 0.6-0.8). There were no statistically significant differences in scores between male and female students or between first and subsequent interviews.

Confidence and competence
Students used a 4-point scale from not at all (1) to completely (4) confident or competent in relation to approaching patients for basic medical interviews. Overall, students' ratings increased after participating in the session ($p<0.001$) (Table 3). Scores for confidence showed that 142 (43%) increased, 176 (53%) remained the same and 13 (4%) decreased. For perceived competence, 150 (44%) increased, 179 (53%) remained the same and 11 (3%) decreased.

Table 3: Students' ratings of their confidence and competence in communicating with patients pre- and post-session (n=333)

	Confidence	Competence
Post < Pre: No. of students %	13 (4%)	11 (3%)
Post = Pre: No. students (%)	176 (53%)	179 (53%)
Post > Pre: No of students (%)	142 (43%)	150 (44%)
z scores	-10.224	-10.792
2-tailed p value	P<0.001	P<0.001

Focus group interviews
Twenty-two students participated in four focus group interviews of between five and six students. Comments were classified into the following topics: overall impressions, preparation for meeting real patients, patients' roles, students' performances, length of interviews and rating forms (Figure 3).

Figure 3: Students' (S) comments from the focus group (FG) interviews (6 interviews with between 5 and 6 students)

Overall impressions
I thought it was really useful. I turned up fairly nervous, not really knowing what to expect or what questions to ask. But when I got to my first patient they were really open and kind of led the interview more than I needed to. But later on I had to lead the other patients as they were less talkative. Something I think we kind of needed was more questions to ask as I got lost and it was due to a lack of knowledge. But definitely useful for building confidence (FG2, S3)
The whole thing went really quickly and was a really good experience. But the only thing was that when the bell went I still hadn't closed as it was hard to keep track of time. (FG4, S1)
It built on our other sessions so we are just gradually getting ready for the real thing. Some of this stuff sounds really easy but well doing it is different. (FG3, S2)

Prepare you for meeting real patients
This is obviously a new thing. I found it really helpful. I mean to go up to people in a waiting room was really helpful. It is realistic enough to prepare you for what really happens. (FG1, S3) Student is repeating year 1

Patients' roles
Great, they were really good, obviously well briefed. I think they knew our objectives quite well… As it went along... by the time you got the to the last one I think they got tired (FG1, S3)
My patient was actually going through it at the time. I really felt what empathy was.
What he was actually telling me I was quite taken aback (FG1, S5)
The older volunteers seemed better than the younger volunteers - maybe someone slightly older would take it more seriously. Would also prefer a mix of ages (FG4 S3)
It was a good experience, especially as we've not had the opportunity to interact in that way with people our age. I'm more used to interacting with patients much older or much younger. I found it quite difficult to treat someone my age as a patient rather than someone I've just met so that was a good point. (FG2 S5)

Students' performances
I think for me it was useful because I was able to identify the areas that I needed to work on. Doing three in a row, it was really clear what worked well and didn't (FG1, S5)
I found I improved because we were told to write down what worked well and what didn't. You don't tend to think about it afterwards but writing it down forces you to do it. It worked really well. It really focused your attention. It's not something you usually do. (FG1, S5)
I went for the first interview intending to improve with each one. Would have been better to have more, but not too many so that everyone gets tired. It was fun with two, but I could have done with one more just to perfect it right at the end (FG4 S2)
I found it easier to keep the flow of conversation with the second one, and she was really chatty and helped put me at ease. I think I do need to improve my confidence though as I was very anxious, and found myself saying 'um' a lot and not being able to form sentences properly. (FG4 S1)
I think I feel slightly less confident as I've become more aware of uncomfortable silences - trying to get those questions out. But it has raised my awareness and given me something to reflect on - so I can now work out how to improve on that. (FG3 S2)

Length of interviews
Each patient was definitely different. Some patients you would need more time but 5 minutes is ok. Being a medical student and not a doctor it was probably about right for finding out why they had come to the doctors. Besides they were to go and see a doctor after us so I think that is fair. (FG1 S3)
What would be nice is if you could just talk until you reached a natural end. You don't want to make it longer (FG2 S2)

Rating forms
Being able to read it after the interview. I could see straight away and see the comments. (FG1 S5)
I find it quite difficult to see myself as others do. Someone else's opinion is invaluable. Definitely a good idea. (FG1 S2)
Not that useful - most of them gave 4's when I wasn't that good. I think they were worried about giving us low marks and being too nice. They need to be told they can give us 1's. (FG2 S4)
Maybe extend the evaluation form to ask for one thing that was good and one thing that was bad - more free text (FG4 S3)

Students were overwhelmingly supportive of the session – they enjoyed it, they were challenged, it provided an opportunity to consolidate basic skills and it prepared them for meeting real patients. Students reported that roles seemed realistic, interviewing patients with diverse characteristics (e.g. age, sex and ethnicity) was helpful and that they preferred interviewing VSPs over peers.

Students reported a preference for three interviews, arguing they improved with each interview and this was the optimal number within one session. The 5-minute length was also thought appropriate to meet the goals of the activity. Most students found the written structured forms (goal setting and reflections) helpful and appreciated the scheduled time to complete this during the session. Some students questioned the value of the rating form because they did not think that all VSPs rated them accurately.

Volunteer Simulated Patients

Seventy-one VSPs participated in the session. All completed written evaluation forms after the session. Nineteen participated in 4 focus group interviews of three to six participants. VSPs attended the session for between three and seven hours.

Demographics

Twenty-five of the VSPs came from a local school and were aged between sixteen and nineteen years old. Fifteen were female and ten male. They represented a diverse cultural base identifying their birthplaces as - Eritrea, Iraq, Kenya, Egypt, Algeria, Ethiopia, England, Saudi, Somalia and Mauritius. The average age of the remaining 46 volunteers was 42 years old (19 to 84), 29 female and 17 male who were almost all born in England with small numbers recording their birthplace as the United States, India and Croatia. Occupations varied widely with professional and non-professional categories equally represented as well as retired and never worked. The main reasons for joining the

programme were to help in the education of medical students and to satisfy their curiosity.

Satisfaction with the session
VSPs used a 4-point scale from not at all (1), a little (2), moderately (3) to completely (4) to rate their satisfaction with various aspects of the session. Mean scores for all items were between moderately and completely satisfied. The highest mean scores were for the quality and number of interviews, the rating forms and access to the toilets. The lowest mean scores were for the setting of the interviews and physical comfort (3.1; SD=0.9).

In response to being asked to identify benefits of the programme, VSPs responded with - meeting the medical students, learning about the curriculum, gaining insight into specific communication skills and being asked to think critically about their own health care experiences. VSPs thought they offered something important to the students. Almost all stated that they would like to participate again.

VSP proforma
Analysis of the proformas showed that VSP roles reflected a range of acute (e.g. headache, coughs, colds, fevers, nausea, vomiting, sore throat, indigestion) and chronic (arthritis, knee injury, heart problems, hypertension, back pain, anxiety) conditions.

Focus group interviews
Figure 4 lists selected comments made by VSPs and are listed by theme – students' performances, role proforma and rating forms. An overwhelming sentiment was the level of enthusiasm for, enjoyment and satisfaction with students' performances. VSPs reported that the students seemed to improve as they did more interviews. However, the VSPs readily identified areas for development in student performance (e.g. sitting too close, use of slang/informal language, speaking too quickly). However, this was not always fed back to students. VSPs reported that their roles needed to be based on a problem they had personally experienced. The rating forms were reported as helpful in focusing VSP's attention on aspects of the interaction that were aligned with the students' learning. VSPs thought the forms were relatively easy to use although time and physical ability (e.g. arthritic fingers) prohibited more than a few comments to be written.

Figure 4: Volunteer simulated patients' (VSPs) comments from the focus group (FG) interviews

Students' performances
"I think this is an excellent thing to do. Very good to do at the beginning of the course because they recognise that they are talking to a real person. You can see that by the time they reach the third person, they are less anxious. There is quite a difference having the students speak to you if it was their first one or the third one. They are improving and they are learning to ask different sorts of questions. You can also see the students that have taken note of the questions that they should be asking.." (FG2 VSP1)
"… because you are out of the room and not hovering also helps them. If the consultant is with them, they are more hesitant about asking questions. Whereas if they are just with us they feel more comfortable. If there is a person in charge observing them it makes them anxious. They don't want to appear stupid." (FG2 VSP2)
"I noticed that as you did the groups of three, the first wasn't very good, the second was better and the third was really good, the best. If they did six they would be excellent, outstanding by the time we did the sixth." (FG4 VSP4)
"Some of the students were nervous. They said it was harder interviewing us because we are their age… That it would be easier if they were interviewing old people." (FG3 VSP2)
"They said to me that they would find older people harder to interview cos they just go on forever." (FG3 VSP4)
"I don't have much contact with young people so it was very reassuring. I was delighted. They had a great deal of empathy." (FG4 VSP2)

Rating forms
"I didn't want to give bad marks. You couldn't exactly give them a poor rating. None of them were really poor." (FG3 VSP6)
I think they were quite comprehensive. (FG1 VSP4)
They were informative. They are simple. (FG1 VSP6)
I tried to put something encouraging on them. (FG1 VSP1)
On a couple I didn't fill them out because we were running out of time. (FG2 VSP3)

Faculty

Recruitment of volunteers
Two academic and two administrative staff were involved in the recruitment phase. VSP recruitment started 6 months prior to the session targeting local community groups. Contact was made by telephone, letter or email. Although interest was expressed, most people were unable to make a commitment to a date several months ahead. Contact was made with a local school who sought interest from their students resulting in a 'guaranteed minimum' number of volunteers for the afternoon session.

Telephone and email activity prevailed during the ten days prior to the session and led to 76 confirmations (an estimated thirty hours work). It was important to be available to explain to volunteers what would be expected in the session and answer their questions. During this period administrative support was required everyday and almost all enquiries could be managed by our administrators.

We received over 200 enquiries and rejected anyone who hinted at being impatient or impolite. We wanted to minimise risk to our medical students bearing in mind that their learning was paramount. High level of challenge in relation to patient character and difficult behaviours were not part of the planned experience. Four people were rejected on this basis. No single method of recruitment yielded outstanding results. Having a friend join the programme was valued. Several potential volunteers declined to participate because we did not offer transport reimbursement. All VSPs who confirmed their

attendance showed up as promised. There were fewer students from the local school than expected due to illness.

VSP session
Four administrative and two academic staff attended the session. We were supported by four senior medical students who directed VSPs and our students to the correct locations, acted as time keepers and helped set up the space. Their costs were £200 in total. Refreshment costs were approximately £150. The session started at 10 am and finished at 5 pm and took place in a multi-disciplinary laboratory. Faculty notes highlight practical areas for improvement such as the flow of human 'traffic' within the building, the importance of offering breaks to VSPs and limiting the number of interviews to twelve in a 3-hour session. Both academic staff at the session reported the critical role of briefing and debriefing of students.

Discussion

The session is a significant logistical exercise that needs to be carefully planned (351 students and 71 VSPs over 6 hours). The results suggest that volunteers can function effectively in supporting the development of patient-centred communication skills in first-year medical students in relation to increasing student confidence and competence. Evaluations from students, VSPs and faculty all point to benefits and satisfaction with the session. However, there are specific aspects of the session that require development.

Students
Key issues identified by students included the opportunity to consolidate basic patient-centred communication skills. Students appreciated the graduated approach of skills acquisition over the sessions in the communication programme – that is, from imparting knowledge of skills, through role-play with peers, then volunteers and looking ahead to interviews with professional actors as SPs and with real patients in clinical settings (Figure 1).

Although there was a statistically significant increase in students' self-report of confidence and competence, this was not reflected in the VSP scores. We were interested in measuring changes in students' perceptions. The results suggest that students benefited from the experience. However, self-report measures do not provide reliable evidence as to actual performance [13,14] and can be conceptually complex for respondents [15]. Still, there is a strong evidence base to support the notion that self-confidence in learning how to do a task influences the learner's approach to acquisition of the skill [16,17]. Providing positive learning experiences in this session may further motivate students to value patient-centred communication.

We anticipated that the session could start to gather evidence of students having difficulties in communication. However, the lack of discrimination in VSP ratings of student performances suggests that either all the students were effective, that VSPs required more guidance in using the form, that more interviews were required or that the rating scale has too few points.

Volunteer Simulated Patients
Ker et al (2005) [18] identify strategies for recruiting SPs to a bank and acknowledge that telephone screening can be acceptable. Since we wanted an annual contribution from volunteers rather than a permanent SP bank for more complex and sophisticated SP roles, our approach had to be quick and simple to administer. Qualities required of SPs have been identified as having a good memory, an ability to role-play, to be committed to attending scheduled sessions, to be 'smart' and have a range of sophisticated communication skills [5,7,18-21]. We cannot be certain that our SPs possessed these qualities as we did nothing more than a superficial screening.

It is important that VSPs complement the educational purpose to which they are contributing – in this instance a fairly limited exposure to students with relatively low level challenge. We believe that many of our VSPs would have been excluded if we had adhered to traditional approaches for recruitment. The diversity of volunteers would have been severely restricted. Instead, diversity became a feature of the experience making the medical school more accessible to our local community.

Although there were risks associated with our minimal screening, we believe that students will encounter uncomfortable interactions with real patients in clinical settings and if they are to occur in a simulated setting then harm is likely to be minimised. During the session, two faculty and administrators were present and available to respond to student or VSP complaints or problems. However, there were no observed or reported difficulties during the interviews or identified at debriefing.

Because the roles were almost all based on volunteers' own experiences, they were relatively authentic and so easy to 'act'. Students' comments supported their realism. However, our guidelines need to be improved so that VSPs look realistic in presentation (e.g. open wounds cannot be presented). Since standardisation of roles was not important, it did not matter that students were exposed to VSPs with differing levels of challenge. The presenting conditions appeared to reflect those that commonly occur in general practice.

We acknowledge the important contribution that highly trained professional SPs make to student education. However, with a limited budget we wanted to find alternative ways to support student learning. Although VSPs and students reported that students' skills improved after their first interview, this was not evidenced in the rating forms. It is possible that forms were not sufficiently discriminating and/or as some VSPs reported in the interviews that they did not feel comfortable recording less than a perfect score. The ability to provide accurate feedback may be one characteristic that distinguishes professional SPs from our VSPs. The range of scores suggests that students performed at a reasonable level. The rating forms may be improved by increasing the number of points on the scale, including more detailed descriptors of items and clarifying terms in the VSP briefing.

Limitations of the study
Some of the limitations have already been cited, especially in relation to measures of confidence and competence. Additionally, there was no control group so we do not know whether participating in the session made a real difference to student's performance in subsequent interviews with real patients. Data was all self-reported except for the ratings of students' by VSPs. Convenience sampling for focus groups may not have reflected all students' and VSPs' views. Although we wanted to raise our College's profile in the local community this is very difficult to measure.

Conclusion

We designed a session to support students in developing patient-centred communication skills. The session proved feasible and relatively inexpensive although a significant logistical exercise. Volunteers from our local community were recruited with minimal vetting to act as simulated patients and provide brief written feedback to students on their performance. Students rated the session highly for educational value. They reported increased confidence and competence after the session although there were no differences in VSPs' ratings of students' communication skills as they progressed through interviews. VSPs also reported that they benefited from the session and almost all wished to participate again. Based on the evaluation results, changes will be made to improve the session such as an improved role profroma, rating form, improved briefing for volunteers and debriefing for students. We would strongly encourage further work with volunteers as SPs in undergraduate medical education.

Acknowledgments

We appreciated the contribution made by the volunteers, Mr Jonathan Wong and Ms Marian Armitage (teachers from the William Morris Academy) and administrative support from Ms Julia Cork and Ms Margaret Reau.

Author Information

At the time of the study all authors were faculty at Imperial College London and responsible for the Clinical Communication Programme.

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