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# Training our future doctors to deliver public health education

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# Training our future doctors to deliver public health education

## **Abstract**

Delivering health education is, as we all know, done for the purpose of trying to encourage people, either individually or as a community, to change their behaviour with the intention of improving their health and well being and preventing certain lifestyle caused illnesses. We would all admit that changing behaviour is difficult and it often takes repeated health messages and much encouragement to effect behavioural change in a person or community. With the aging population and rise in preventable illnesses in our communities, health education has become the responsibility of all health professionals in all forms of contact with individuals or groups. Many studies have shown that doctors have enormous credibility in the eyes of many in the general public and this should be utilised to its maximum potential. Doctors often do not deliver health education as well as they could and it is necessary that we ask why not; and how could we better prepare our future doctors for this aspect of their work. Studies show we only deliver HE a third as often as we should.

## **Keywords**

our, education, training, health, public, deliver, doctors, future

## **Disciplines**

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**Training our future doctors to deliver public health education?**

Dr Helen Rienits

Slide 1

**(An analysis of current teaching methods in the Clinical Skills Centre at the GSM,  
UOW)**

Alice Springs 2011 ANZAHPE Conf.

Concurrent Session 2: Ethics and Education. 4061

MacDonnell Room. Tuesday 28/6/11 1.30pm – 3.00 pm ( check in 1pm) ( No 8)

## Introduction /Background

### Slide 2

- Delivering health education is, as we all know, done for the purpose of trying to encourage people, either individually or as a community, to change their behaviour with the intention of improving their health and well being and preventing certain lifestyle caused illnesses.
- We would all admit that changing behaviour is difficult and it often takes repeated health messages and much encouragement to effect behavioural change in a person or community. [1]
- With the aging population and rise in preventable illnesses in our communities, health education has become the responsibility of all health professionals in all forms of contact with individuals or groups.
- Many studies have shown that doctors have enormous credibility in the eyes of many in the general public and this should be utilised to its maximum potential. [2,3,4,5,6 ]
- Doctors often do not deliver health education as well as they could and it is necessary that we ask why not; and how could we better prepare our future doctors for this aspect of their work. Studies show we only deliver HE a third as often as we should. [3,4,5,7,8,9,10 ]

## Why don't doctors deliver health education as well as they could?

### Slide 3

- The current system of remuneration imposes limits on the time available in the consultation for this aspect of patient care.
- Studies show doctors are more comfortable with giving basic lifestyle advice (eg in diabetes) but less likely to warn of complications. [7] We are uncomfortable with the tougher concept of 'encouragement'.
- Feeling that the patient already knows the information and is not interested. [8] Unrealistic expectations of what it will achieve and having been disappointed with previous results of HE given to patients.
- Doctors have had little training in the basic principles of adult education. (The adult learner needs to see there is a specific purpose to the teaching and to understand the meaning and relevance. They need to be voluntarily and actively involved in the learning. They need clear goals, objectives, feedback and encouragement to reflect.[13])
- Communication skills, as an aspect of medical education, have only been introduced relatively recently (last 10-20yrs), and many older doctors have had no training in them at all. Studies show that in the 1990's 1/3<sup>rd</sup> of the medical schools in the UK and USA had no formal training in communication skills at all. [11,12] This can make mentoring a student in this field difficult for the teacher/preceptor/GP Supervisor.
- Poor follow-up written resources. (Doctors often wish, but lack the time and the training, to be able to make their own written follow up handouts yet are frustrated by the handouts available from health departments, etc.)
- Difficulty recording and following up on Health Information given to a specific patient. Practice software systems are not orientated to health education. Studies show GPs don't think follow up on health education is as important as patients think it is. [3,5,14]

## Goals of interview instruction:

Slide

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There is a growing emphasis on the formal instruction of students in communication skills and this is driven by patient demand. There are 3 main goals of interview instruction: [11] (Kok, D)

- 1) Teaching data gathering skills. All doctors would acknowledge the importance of taking a good history and gathering all the relevant information to help to formulate a diagnosis and decide on management.
- 2) Teaching relationship building skills. This has been shown to improve the patient's willingness to provide information and to encourage the patient to understand and cooperate in the management process.
- 3) Teaching how to educate patients. "The ability to convey complex information to patients in an easily understood manner is often overlooked in curricula" [11 - Kok 2010] This last aspect is usually given the least time and attention and is often poorly structured and delivered, despite the number of studies that show improved patient outcomes following better patient education.[15]

## **Skills for delivering good patient/public health education:**

### **Slide 5**

- Knowledge of health information. Students need to understand what lifestyle changes, etc, are important to focus on to achieve maximum benefit for this patient. (Sources of information both from lectures and journals, etc, are often confusing and contradictory – even for experienced doctors, eg. 'salt'.)
- The skill required to translate the information into simple language which is easily understood and is appropriate to the patient.
- Understanding the particular difficulties the patient or group may have with comprehending, remembering and applying the information. (Average adult reading level – 10-14yr olds, poor English, poor education, lower socioeconomic groups, patients with early dementia, brain damage, depression or anxiety, etc.) [9]
- Students need to be able to develop a realistic expectation of just what their health education/advice can achieve in one session and how to structure and deliver in appropriate 'bite-sized ' chunks. [18]
- Basic principles of educating adult learners. [13]
- Students need to know how to access (? and design their own) patient information, both in the form of written handouts and Web based sources, for patients to follow up.

## **Teaching students to deliver health education at the GSM, UOW.**

### **Slide 6**

- Lectures (Phase 1 & 2). Some references are made to this aspect in the introductory lectures on communication skills. Specific lectures: “Motivational interviewing”,
- Student observation of faculty members and GP preceptors delivering health information. (With real patients and via GOALs) – all Phases. (Guided On Line Assessable Learning activities)
- Self Directed Learning and assignments – (limited effectiveness) [11]
- Discussion groups (CBLs) and Tutorials
- Clinical Skills: 3 sessions (1hr) with simulated patients in the first Phase (18mths) of the course before the students go into wards and general practices in a major way.
- Practice with real patients in phase 2, 3 & 4.
- OSCE station assessment



## **Clinical Skills session: “Giving Information & Instruction”**

### **Slide 7**

This 1 hr lesson is held in Phase 1 session 1 – approximately 4mths into the course. The students are doing respiratory medicine at the time so to integrate this into the course, they are asked to explain the basic pathology of asthma to a simulated patient and instruct them on the use of an inhaler device.

- Pre reading consists of a short video and instruction sheet on demonstrating the use of the inhaler device to a patient. The students are also provided with simple educational pictures of asthma pathology for use with the patient.
- 20mins - Tutor led group (of 6-8 students) discussion on what constitutes good patient education and instruction. Vol patients are included in this discussion too.
- 15mins - Working in pairs, one student explains asthma to the patient and instructs them on the use of the inhaler, using the pictures and a placebo device. The other student observes and completes a modified Calgary/Cambridge Feedback form for their peer. After 10mins, the student is invited to reflect on their performance and then both the patient and peer student provide feedback.
- 15mins – The students move to another patient and the second student repeats the process. The students are supervised throughout by the tutor who also provides feedback.
- 10mins – At the end the group reconvenes and have a brief time to share their experiences and reflections. At most Communication and History taking sessions at the GSM Clinical skills we set up video cameras for students to record themselves as they work with the patient. Students are encouraged to collect the copy of the film of themselves afterwards and take it home for further self evaluation. Studies show that both feedback from patients, peers and tutors as well as self evaluation and reflection are strong facilitators for learning communications skills.[16,17]
- This lesson has been formally evaluated and the student’s comments were interesting:
  - How hard it is to explain medical concepts simply without medical jargon.
  - How important it is to know what you are talking about.
  - How important the skill of teaching is!

- Overall they rated it a 'great session' and said they really appreciated the pts.

### **Clinical Skills session: “Motivational Interviewing”**

#### **Slide 8**

This 1 hr lesson is held in Phase 1 session 2 - approximately 8mths into the course. As this session is held at the time the students are studying Diabetes in their integrated program, we ask the students to interview a simulated patient with type 2 diabetes who is along for their annual check. The students are asked to assess the patient with regard to lifestyle modification issues, to determine aspects that need change, assess readiness to change and work from there to motivate the patient to change.

- Students have a lecture prior to the skills session on the principles of motivational interviewing and assessing stage of change. They are also given information to read and example videos to watch as pre reading.
- 10min - Tutor led group (6-8 students) discussion on the SNAP model to identify lifestyle issues and assess stage of readiness to change.
- 30min – working in pairs, one student works with a patient while the other student observes and completes a modified Cal/Cam feedback form and then students swap roles and repeat with a second patient. Patients, peers, tutor and the student all provide feedback.
- 20min - The group reconvenes to share difficulties and learning experiences
- Tutor feedback to the Clinical Skills staff suggests that the students find this a difficult session. This is not a simple history taking session in which you try to work out a diagnosis. This is their first glimpse at the complexity of management of chronic disease and the importance and relevance of health education for prevention of complications.

## **Clinical Skills session: “Patient Centred Decision Making”**

### **Slide 9**

This 1 hr lesson was originally held in the early part of the first year but clearly the students have not coped at all well with it this early. It has now been moved to Phase 1 session 3 and the students will be about 15mths into the course. As the students are in their Haematology block, the cases are based around patients with various illnesses in this field who also have their own ideas on management. The students are asked to discuss the various management options with the patient and work out with the patient the option which will be most suitable and acceptable to the patient.

- Students are given information to read and example videos to watch as pre reading.
- 10min - Tutor led group (6-8 students) discussion on the concepts of patient centred decision making.
- 30min – working in pairs, one student works with a patient while the other student observes and completes a modified Cal/Cam feedback form and then students swap roles and repeat with a second patient. Patients, peers, tutor and the student all provide feedback.
- 20min - The group reconvenes to share difficulties and learning experiences
- Again this is a difficult concept for students to tackle. Part of the problem lies in the terms used in the communication textbooks and the different meaning of the terms used by doctors in practice. eg ‘concordance’ v. ‘compliance’. This in turn reflects the fact that many doctors themselves have problems with patient centred decision making. (Although many experienced GPs have been doing it for years without realising what they are doing.) Studies show that in acute illness, patients are more willing to follow direct advice from the doctor but in chronic illness, patients prefer to consult and discuss options. [18]

## **Problems we encounter in training our medical students to deliver health education Slide 10**

- Students find it difficult in the early stages of the course as they don't have the background knowledge but we don't have the time with students to teach these aspects in a practical way in Phases 2, 3, & 4.
- It has been a struggle to place these lessons in the integrated course so that the lesson has relevance and builds on their current learning but with some juggling we have achieved this.
- At the GSM, we also aim for what we call a spiral curriculum. That means we want to revisit material at the next level for students to build on lessons learned. There is potential for this to happen in the 3 following phases but it is not as coordinated as it could be yet. It is in these phases that students could put the principles into practice.
- Despite these problems, our students have learnt and we have been very impressed with their performance at OSCEs and as interns in this area. We feel this is due to the actual practical nature of our skills teaching with simulated patients.

## Future directions for teaching health education

Slide

11

- One of the drawbacks of small group teaching across different campuses is equity for all students. Sometimes the insertion of a large group lecture introducing the basic principles before the practical session not only helps to ensure all are on the same wavelength but also frees more time for the practical part.
- Use of video cameras and student self evaluation has been shown to be a powerful teaching tool but it is difficult to get students to engage with this tool as many of us don't like watching ourselves on video. Is assessment a possibility?
- Should we set an activity/assignment to get students to design a simple health education brochure on a topic?
- The learning outcomes for these sessions need to be clearer to the students (and possibly simpler) so that students understand exactly what they are doing and why.
- Use doctors to teach these lessons as well as other Health Profession educators as studies show that students engage less if they do not think it is a doctor's job.[12]
- Need to introduce some teaching on the use of memory aides eg categorization, prioritizing, etc. Also students need to be alerted to the groups of patients who are going to have difficulty understanding, remembering and applying health education. [14]

"I hear and I forget. I see and I remember. I do and I understand"  
(Confucius 551-479 BC)

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Slide 12

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