Implementation of a patient-based feedback tool to assess the CanMEDS-FM communicator role

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The CanMEDS–Family Medicine (CanMEDS-FM) communicator role emphasizes the critical nature of information exchange in family medicine, noting its myriad effects on patient satisfaction and safety, among other psychological and physiological outcomes of care.[1-3] Communication skills are important "for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care."[4] In the era of competency-based medical education, it therefore behooves clinical educators to evaluate the competencies relevant to the communicator role in a fulsome, reliable, and valid way. This has proven difficult for some family medicine programs, particularly those that rely on community-based or rural and remote preceptors, who often cannot directly observe trainees as they provide care (eg, using a closed-circuit camera system). Further, evaluations that are undertaken almost always omit patients' perspectives, unnecessarily excluding their voices and sacrificing potentially valuable educational feedback in the process.[5]

Evidence

The literature on the evaluation of communication skills in residents is voluminous.[6] Only a small proportion of this work, however, has focused specifically on family medicine residents. This is problematic, as the nature of the patient-physician relationship in family medicine is arguably distinct from that in specialty practices, including greater emphasis on affiliation, rapport, and longitudinal continuity of care. Tools that are derived in specialty contexts might, therefore, fail to optimally translate to the family medicine milieu. Notwithstanding, the literature does document the development of various tools to assess communication-related competencies, including objective structured clinical examinations, behavioural checklists for clinical encounters, and general rating forms.[5,7-9] With extremely few exceptions though,[7] there is a general failure to involve patients in the evaluation process—a serious concern. Physicians and patients have been shown to harbour different perceptions of a given clinical encounter[10]; evaluating a resident's performance based exclusively on the teacher's impression might consequently render the feedback vulnerable or incomplete. Further, it is hard to claim that we are arming residents with patient-centred communication competencies if we consistently fail to solicit and attend to the patient experience in our educational programs.

Our experience

We sought to develop a patient-based survey tool to contribute to our assessment of the CanMEDS-FM communicator role in our family medicine teaching unit (University of Toronto Department of Family and Community Medicine, University Health Network–Toronto Western Hospital in Ontario) (**Table 1**).* We began the process of developing the tool in the 2010-2011 academic year, adapting a pre-existing, unpublished instrument from the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and the Medical Council of Canada. The tool was introduced to residents in their postgraduate "Partners in Care" course, which imparts general principles of patient-centred clinical care,[11] primarily during the first year of residency.

We employed a continuous quality improvement (plan, do, study, act) model[12] to modify the tool and process based on repeated consultation with faculty physicians and residents over 5 academic years. In its first iteration, 10 first-year residents personally distributed the survey to their patients during 2 or 3 preassigned half-days of clinic and immediately reviewed survey results with their preceptors after each half-day.

Over the years, the survey item format was revised from a Likert-type scale to a binary yes-or-no format, as it became apparent that patients uniformly avoided the lower points on the numerical scale. The option for written commentary was also introduced, leading to richer, more personal narrative feedback. We also

Table 1. Tools and resources: *The following were helpful in the implementation of our patient-based survey; all are available from CFPlus.**

TOOL	PURPOSE
Patient-based feedback tool	To be disseminated to patients (electronically or manually) to solicit feedback on communication skills; assures anonymity
Preceptor guide	A brief guide to support preceptors in the review of survey results with their residents
Resident guide	A brief guide to support residents in interpreting their survey results

*The **patient-based feedback tool** and the **preceptor** and **resident guides** are available at **www.cfp.ca**. Go to the full text of the article online and click on the **CFPlus** tab.

provided a cover letter signed by the Postgraduate Site Director explaining the rationale for the request and assuring anonymity. We experimented with survey distribution methods, allowing reception staff (rather than residents) to hand the survey tools to patients. Although this removed the concern about potential bias (ie, that residents could adjust their performance on days they were aware their communication skills were being rated by their patients), the return rate declined substantially.

As our unit began to employ e-mail communication with patients more routinely, our most recent iteration of this effort involved e-mailing the survey tool (and cover letter) to patients immediately after a visit with one of our first-year residents. E-mailed surveys were sent out for a period of approximately 6 months, at which time feedback was shared with residents and their preceptors in aggregate for discussion at a scheduled progress review meeting. This process has worked most ideally for our unit, allowing larger sample sizes (closer to the minimum recommended range of 20 to 50[9]) and, therefore, more robust feedback. It has also integrated the process into our curriculum in a truly seamless way, signaling to residents that patient feedback is a metric we take seriously in considering their communication skills. Finally, it allows possible deficiencies to be addressed at the precise point that learning goals and plans are negotiated.

Response from both faculty and residents to the feedback tool has been almost exclusively positive, with unanimous agreement to continue its use moving forward. Evaluations of the initiative included comments from residents, such as "informative," and "good way to think about my bedside manner," and from faculty members, such as "when positive, it is reaffirming; when negative, it is eye-opening."

Conclusion

Consider a patient-based feedback tool in the evaluation of trainee CanMEDS-FM communicator competencies (**Table 1**).* Survey distribution should continue for a long enough duration to accrue a robust sample of responses. Responses should be reviewed in aggregate with the guidance of a resident's preceptor, who is already familiar with the resident's educational trajectory and performance, and who can help contextualize patient feedback and inform the development of appropriate learning goals.

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Competing interests

None declared

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Teaching tips

- Consider a patient-based feedback tool in the evaluation of trainee CanMEDS–Family Medicine communicator competencies, particularly in community-based and rural or remote settings where the opportunity for direct observation of residents with patients might be limited. As the tools provide powerful collateral, independent feedback directly from patients, they can also be useful for trainees in difficulty or on remediation programs.
- If possible, use electronic dissemination to distribute surveys to patients. If this is not an option, surveys should be distributed by reception staff (rather than trainees). Survey distribution should continue for long enough to accrue a robust sample size of responses. Responses should be reviewed in aggregate with the guidance of the resident's preceptor.
- Trainees should be well-oriented to the process, ideally as part of a curriculum on communication and patient-centred clinical methods. (If survey distribution is scheduled to occur on a small number of days, however, trainees should not be made aware of which days in order to avoid bias or adjustment of their performance.)
- Consider incorporating a patient-feedback survey tool into a fulsome 360° (multisource) feedback process, in which feedback on communication skills is additionally collected from supervising physicians and allied health team members.

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