
Maintaining a cohesive medical group requires more than partners who get along with one another. Physicians must share the same values and be willing to give (and graciously receive) honest feedback on issues such as quality of care, technical competence, patient- and staff relations, behavior, work ethic, and productivity. This article shows group leaders how to start this process by mentoring new physicians and how to then extend the process to include all physicians in the group. Medical practices that have evaluation systems in place enjoy benefits that include better communication, accountability, increased retention rates, and a more unified group. Many physician groups avoid the evaluation process because they are not comfortable “judging” their peers, they don’t know how to approach the process, or they don’t want to invest the time. This article presents alternative approaches to establishing a mentoring and evaluation process, shows group leaders how to identify which is right for them, and provides do’s and don’ts for a smooth implementation of the process.


These studies examine employees’ emotional reactions to performance feedback from their supervisors as well as subsequent effects on attitudes and (intentions to show) affect-driven work behaviors (counterproductive behavior, turnover, citizenship, and affective commitment). A pre-study (N = 72) illustrates that employees regularly receive performance feedback from supervisors and that this feedback elicits different positive and negative emotions. Next, a scenario experiment (Study 1) comparing the effects of positive/negative feedback given in public/private was conducted, with a student sample (N = 240) and a sample of working adults (N = 107). In both samples, feedback has an impact on emotions and subsequently on work attitudes and behavioral intentions. The results from the scenario experiment were validated in a survey study (Study 2) among employees of a for-profit research firm (N = 86) who reported on recalled emotions and work behaviors after receiving performance feedback during appraisals. Again, different types of feedback relate to different emotions. In turn, these emotions were related to subsequent work behaviors and attitudes. Together, these studies show that feedback affects recipients’ emotions and that such emotional reactions mediate the relationship between feedback and counterproductive behavior, turnover intentions, citizenship, and affective commitment.


Developing and maintaining professional relationships requires a solid foundation of communication skills—skills that people are not generally taught, but that are vital to all personal and professional interactions. In this article, the authors address one critical, but often neglected form of communication: feedback.

In health professions education, feedback can be defined as the sharing of information about a student's performance. The most valuable learning occurs when students receive detailed feedback delivered in a way they can utilize it. In clinical simulations, feedback from a standardized patient (SP) offers a unique perspective. This article presents some of the underlying theory and research on feedback delivery with a particular emphasis on the role of non-verbal communication. We explore what feedback students need from SPs, how to provide feedback effectively as well as common challenges to the process. The authors, working from different health care disciplines, collaborated to develop a training workshop for the college's SPs designed to ensure a consistent approach to SP feedback delivery. We describe this workshop and its outcomes.


**BACKGROUND:** Student ratings have dominated as the primary and, frequently, only measure of teaching performance at colleges and universities for the past 50 years. Recently, there has been a trend toward augmenting those ratings with other data sources to broaden and deepen the evidence base. The 360 multisource feedback (MSF) model used in management and industry for half a century and in clinical medicine for the last decade seemed like a best fit to evaluate teaching performance and professionalism.

**AIM:** To adapt the 360 MSF model to the assessment of teaching performance and professionalism of medical school faculty.

**METHODS:** The salient characteristics of the MSF models in industry and medicine were extracted from the literature. These characteristics along with 14 sources of evidence from eight possible raters, including students, self, peers, outside experts, mentors, alumni, employers, and administrators, based on the research in higher education were adapted to formative and summative decisions.

**RESULTS:** Three 360 MSF models were generated for three different decisions: (1) formative decisions and feedback about teaching improvement; (2) summative decisions and feedback for merit pay and contract renewal; and (3) formative decisions and feedback about professional behaviors in the academic setting. The characteristics of each model were listed. Finally, a top-10 list of the most persistent and, perhaps, intractable psychometric issues in executing these models was suggested to guide future research.

**CONCLUSIONS:** The 360 MSF model appears to be a useful framework for implementing a multisource evaluation of faculty teaching performance and professionalism in medical schools. This model can provide more accurate, reliable, fair, and equitable decisions than the one based on just a single source.
Patients with chronic conditions make day-to-day decisions about—self-manage—their illnesses. This reality introduces a new chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education. Self-management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care.

**BACKGROUND:** While Motivational Interviewing (MI) is effective in reducing client problem behaviours, including health-related behaviours, there is little evidence about how MI training enhances practitioner skills.

**AIMS:** The current pilot study addressed this lack by training two health practitioners (Diabetes Nurse Educators) in MI, and evaluated the effect of MI training on both practitioner and patient behaviour when MI was delivered in a clinical setting, with patients experiencing difficulties with diabetes self-management.

**METHODS:** Comparisons were made between the practitioners’ skills in a baseline condition (Patient Education; PE) and after training in Motivational Enhancement Therapy (MET), a four-session form of MI. At the same time, the effects of the two interventions on patient in-session behaviour were compared. Practitioner and patient data were obtained from transcripts of all PE and MET sessions, which were independently coded using Motivational Interviewing Skills Code therapist and client behaviour counts.

**RESULTS:** Compared with their baseline performance, practitioners, when trained to practice MET, behaved in ways consistent with MI, and this appears to have evoked beneficial in-session behaviour from the patients.

**CONCLUSIONS:** These results suggest that the MI training was effective.


There is evidence that patient-centred approaches to health care consultations may have better outcomes than traditional advice giving, especially when lifestyle change is involved. Motivational interviewing (MI) is a patient-centred approach that is gathering increased interest in health settings. It provides a way of working with patients who may not seem ready to make the behaviour changes that are considered necessary by the health practitioner. The current paper provides an overview of MI, with particular reference to its application to health problems.


**BACKGROUND:** Patients want all their concerns heard, but physicians fear losing control of time and interrupt patients before all concerns are raised.

**OBJECTIVE:** We hypothesized that when physicians were trained to use collaborative upfront agenda setting, visits would be no longer, more concerns would be identified, fewer concerns would surface late in the visit, and patients would report greater satisfaction and improved functional status.
DESIGN AND PARTICIPANTS: Post-only randomized controlled trial using qualitative and quantitative methods. Six months after training (March 2004-March 2005) physician-patient encounters in two large primary care organizations were audio taped and patients (1460) and physicians (48) were surveyed.

INTERVENTION: Experimental physicians received training in upfront agenda setting through the Establishing Focus Protocol, including two hours of training and two hours of coaching per week for four consecutive weeks.

MAIN MEASURES: Outcomes included agenda setting behaviors demonstrated during the early, middle, and late encounter phases, visit length, number of raised concerns, patient and physician satisfaction, trust and functional status.

KEY RESULTS: Experimental physicians were more likely to make additional elicitations (p < 0.01) and their patients were more likely to indicate agenda completion in the early phase of the encounter (p < 0.01). Experimental group patients and physicians raised fewer concerns in the late encounter phase (p < 0.01). There were no significant differences in visit length, total concerns addressed, patient or provider satisfaction, or patient trust and functional status.

CONCLUSION: Collaborative upfront agenda setting did not increase visit length or the number of problems addressed per visit but may reduce the likelihood of “oh by the way” concerns surfacing late in the encounter. However, upfront agenda setting is not sufficient to enhance patient satisfaction, trust or functional status. Training focused on physicians instead of teams and without regular reinforcement may have limited impact in changing visit content and time use.


OBJECTIVES: Evidence suggests that the most important component of communication skills training (CST) is experiential learning through role-play sessions that rely on facilitators to guide learners. However, there is little published evidence about processes of assessing facilitator competence in CST. This paper reports on the development and application of procedures to assess facilitator competence in a large-scale CST programme.

METHODS: Thirty-two novice facilitators in a large CST programme were audio-recorded while facilitating small-group CST training sessions in order to explore whether the training they had received had prepared them to competently facilitate. Audio-recordings were assessed using the Comskil facilitator assessment coding system. Facilitators were rated as having achieved basic competence, advanced competence or expert competence.

RESULTS: Facilitation tasks that were most frequently coded as being used always included inviting the learner to give feedback first and inviting all group members to give feedback. The facilitation task coded least frequently as being used always was involving group members in solving problems. Of the 32 facilitators, 18 reached at least a basic level of competence. Psychosocially trained facilitators and MD facilitators differed in their use of five facilitation tasks.

CONCLUSIONS: Modest training and minimal practice does not result in complete facilitator competence. Some facilitation skills appear to be more easily acquired than others. These findings highlight which skills should be prioritized in the further training of novice facilitators.
facilitators. A long-term project currently underway will study whether facilitator competence improves with practice and regular feedback.


**OBJECTIVE:** The relationships between the occupational, educational, and verbal-cognitive characteristics of health care professionals and their motivational interviewing (MI) skills before, during, and after training were investigated.

**METHOD:** Fifty-eight community-based addiction clinicians (M 42.1 years, SD 10.0; 66% Female) were assessed prior to enrolling in a 2-day MI training workshop and being randomized to one of three post-workshop supervision programs: live supervision via teleconferencing (TCS), standard tape-based supervision (Tape), or workshop training alone. Audiotaped sessions with clients were rated for MI skillfulness with the Motivational Interviewing Treatment Integrity (MITI) coding system v 2.0 at pre-workshop and 1, 8, and 20 weeks post-workshop. Correlation coefficients and generalized linear models were used to test the relationships between clinician characteristics and MI skill at each assessment point.

**RESULTS:** Baseline MI skill levels were the most robust predictors of pre and post-supervision performances. Clinician characteristics were associated with MI Spirit and reflective listening skill throughout training and moderated the effect of post-workshop supervision method on MI skill. TCS, which provided immediate feedback during practice sessions, was most effective for increasing MI Spirit and reflective listening among clinicians with no graduate degree and stronger vocabulary performances. Tape supervision was more effective for increasing these skills among clinicians with a graduate degree. Further, TCS and Tape were most likely to enhance MI Spirit among clinicians with low average to average verbal and abstract reasoning performances.

**CONCLUSIONS:** Clinician attributes influence the effectiveness of methods used to promote the acquisition of evidence based practices among community-based practitioners.


The number and cost of preventable medical injuries and deaths continue to rise in the U.S. healthcare system despite many attempts to avert such occurrences. The Centers for Medicare & Medicaid Services has prudently decided to deny claims for the healthcare costs incurred in treating certain preventable injuries. With the passage of a the Patient Protection and Affordable Care Act, the list of denied healthcare procedures to correct preventable medical injuries will grow, resulting in a further squeezing of the profit margins of medical institutions and providers. In this article, we show that business coaching of the healthcare team is successful in reversing the alarming growth rate of medical errors, thus ensuring the financial success of healthcare institutions adopting business coaching practices.

In the 1990s, managed care became the model for healthcare delivery in the United States with the goals of delivering healthcare to a greater number of patients at reduced costs. Although the goals were laudable, the increased number of patients receiving healthcare has resulted in less time per encounter, thereby weakening the patient-physician relationship. In this article, professional coaching skills are presented that show how to regain the quality of the physician-patient relationship. This improved rapport will result in more successful patient outcomes and reduced healthcare costs.


Giving feedback means offering someone information about his or her behavior that we either like or don’t like. It takes awareness and skill to give critical feedback effectively. It’s an art to tell someone that we don’t like what they did and what we would like them to do differently in the future while keeping, or creating, a friendly connection with them. It also means if you are on the receiving end of feedback that it can be difficult to hear “critical” feedback calmly even when it is delivered with the proper “I” messages and real feeling words. It can be painful for two reasons. The critical statements or the harshness of the delivery can hurt. And you can wonder whether, and to what extent, it’s true.


The authors outline key points about feedback for staff to consider in everyday practice, with a view to making the task less daunting. In turn, we address the meaning of feedback, elements of good feedback, placement objectives, setting, frequency, identifying areas of weakness, recognition and praise, dealing with unfavorable reactions, and dissatisfaction with the feedback process.


Medicine is a learned profession, but clinical practice is above all a matter of performance, in the best and deepest sense of the word. Because music is, at its core, a pure distillate of real-time performance, musicians are in an excellent position to teach us about better ways to become and remain expert performers in health care and ways for our teachers and mentors to help us do that. Ten features of the professionalization of musicians offer us lessons on how the clinical practice of medicine might be learned, taught, and performed more effectively.

CONTEXT: Core physician activities of lifelong learning, continuing medical education credit, relicensure, specialty recertification, and clinical competence are linked to the abilities of physicians to assess their own learning needs and choose educational activities that meet these needs.

OBJECTIVE: To determine how accurately physicians self-assess compared with external observations of their competence.


STUDY SELECTION: Studies were included if they compared physicians' self-rated assessments with external observations, used quantifiable and replicable measures, included a study population of at least 50% practicing physicians, residents, or similar health professionals, and were conducted in the United Kingdom, Canada, United States, Australia, or New Zealand. Studies were excluded if they were comparisons of self-reports, studies of medical students, assessed physician beliefs about patient status, described the development of self-assessment measures, or were self-assessment programs of specialty societies. Studies conducted in the context of an educational or quality improvement intervention were included only if comparative data were obtained before the intervention.

DATA EXTRACTION: Study population, content area and self-assessment domain of the study, methods used to measure the self-assessment of study participants and those used to measure their competence or performance, existence and use of statistical tests, study outcomes, and explanatory comparative data were extracted.

DATA SYNTHESIS: The search yielded 725 articles, of which 17 met all inclusion criteria. The studies included a wide range of domains, comparisons, measures, and methodological rigor. Of the 20 comparisons between self- and external assessment, 13 demonstrated little, no, or an inverse relationship and 7 demonstrated positive associations. A number of studies found the worst accuracy in self-assessment among physicians who were the least skilled and those who were the most confident. These results are consistent with those found in other professions.

CONCLUSIONS: While suboptimal in quality, the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess. The processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment.


OBJECTIVE: To review the literature relating to the effectiveness of education strategies designed to change physician performance and health care outcomes.

DATA SOURCES: We searched MEDLINE, ERIC, NTIS, the Research and Development Resource Base in Continuing Medical Education, and other relevant data sources from 1975 to 1994, using continuing medical education (CME) and related terms as keywords. We manually searched journals and the bibliographies of other review articles and called on the opinions of recognized experts.
STUDY SELECTION: We reviewed studies that met the following criteria: randomized controlled trials of education strategies or interventions that objectively assessed physician performance and/or health care outcomes. These intervention strategies included (alone and in combination) educational materials, formal CME activities, outreach visits such as academic detailing, opinion leaders, patient-mediated strategies, audit with feedback, and reminders. Studies were selected only if more than 50% of the subjects were either practicing physicians or medical residents.

DATA EXTRACTION: We extracted the specialty of the physicians targeted by the interventions and the clinical domain and setting of the trial. We also determined the details of the educational intervention, the extent to which needs or barriers to change had been ascertained prior to the intervention, and the main outcome measure(s).

DATA SYNTHESIS: We found 99 trials, containing 160 interventions, that met our criteria. Almost two thirds of the interventions (101 of 160) displayed an improvement in at least one major outcome measure: 70% demonstrated a change in physician performance, and 48% of interventions aimed at health care outcomes produced a positive change. Effective change strategies included reminders, patient-mediated interventions, outreach visits, opinion leaders, and multifaceted activities. Audit with feedback and educational materials were less effective, and formal CME conferences or activities, without enabling or practice-reinforcing strategies, had relatively little impact.

CONCLUSION: Widely used CME delivery methods such as conferences have little direct impact on improving professional practice. More effective methods such as systematic practice-based interventions and outreach visits are seldom used by CME providers.


CONTEXT: The Reporter–Interpreter–Manager–Educator (RIME) evaluation framework is intuitive and reliable. Our preceptors’ frustration with using summative tools for formative feedback and the hypothesis that the RIME vocabulary might improve students’ and preceptors’ experiences with feedback prompted us to develop and pilot a RIME-based feedback tool.

METHOD: The tool was based on the RIME vocabulary, which has previously been used for evaluation. As interpersonal skills and professionalism are difficult areas in which to give feedback, we added these as explicit categories. We piloted the tool in a longitudinal, 5-month, multi-specialty clerkship. Preceptors completed pre- and post-introductory workshop surveys. Students completed post-workshop and post-clerkship surveys.

RESULTS: Preceptors (n = 14) and students (n = 8) preferred RIME-based feedback to ‘usual feedback’ (previously given using end-of-clerkship evaluation forms). After the initial workshop, preceptors expected that giving feedback, including critical feedback, would be easier. After the 5-month clerkship, students reported receiving more feedback than in previous clerkships and rated feedback given using this tool more highly (P = 0.002; effect size 1.2). Students also felt it helped them understand specifically how to improve their performance (P = 0.003; effect size 1.2).

DISCUSSION: In this pilot study, preceptors and students preferred feedback with a specific RIME-based tool. Students felt such feedback was more useful and helped them identify specifically how to improve. Whether this method can improve student performance through improved feedback remains an area for further research.

**INTRODUCTION:** Deficient physician communication skills can lead to complaints by patients and colleagues. While there are many communication training courses for physicians, there are few descriptions of programs that address their deficiencies.

**AIM:** This report describes the use of a coaching model developed by the author to remediate inadequate communication skills.

**PROGRAM DESCRIPTION:** The coaching model consists of a discrete set of communication skills that are gradually integrated into professional activities while debriefing that process in a supportive relationship.

**PROGRAM EVALUATION:** Outcomes are provided for the first 13 physicians coached after the approach was standardized. On a Likert scale (range, 1-7), with 7 expressing “high satisfaction,” all participants rated the consultation in the 5-7 range (mean, 6.3), and all supervisors rated the consultation in the 6-7 range (mean, 6.7).

**DISCUSSION:** A coaching model is effective in improving communication skills deemed inadequate by physicians’ patients and colleagues. Future work should evaluate the impact of integrating coaching into health care organizations and on developing new tools to augment coaching.


**BACKGROUND:** A consulting method known as ‘shared decision making’ (SDM) has been described and operationalized in terms of several ‘competences’. One of these competences concerns the discussion of the risks and benefits of treatment or care options—‘risk communication’. Few data exist on clinicians’ ability to acquire skills and implement the competences of SDM or risk communication in consultations with patients.

**OBJECTIVE:** The aims of this study were to evaluate the effects of skill development workshops for SDM and the use of risk communication aids on the process of consultations.

**METHODS:** A cluster randomized trial with crossover was carried out with the participation of 20 recently qualified GPs in urban and rural general practices in Gwent, South Wales. A total of 747 patients with known atrial fibrillation, prostatism, menorrhagia or menopausal symptoms were invited to a consultation to review their condition or treatments. Half the consultations were randomly selected for audio-taping, of which 352 patients attended and were audio-taped successfully. After baseline, participating doctors were randomized to receive training in (i) SDM skills or (ii) the use of simple risk communication aids, using simulated patients. The alternative training was then provided for the final study phase. Patients were allocated randomly to a consultation during baseline or intervention 1 (SDM or risk communication aids) or intervention 2 phases. A randomly selected half of the consultations were audio-taped from each phase. Raters (independent, trained and blinded to study phase) assessed the audio-tapes using a validated scale to assess levels of patient involvement (OPTION: observing patient involvement), and to analyse the nature of risk information discussed. Clinicians completed questionnaires after each consultation, assessing
perceived clinician-patient agreement and level of patient involvement in decisions. Multilevel modeling was carried out with the OPTION score as the dependent variable, and rater, consultation and clinician levels of data, standardized by rater within clinician.

RESULTS: Following each of the interventions, the clinicians significantly increased their involvement of patients in decision making (OPTION score increased by 10.6 following risk communication training [95% confidence interval (CI) 7.9 -13.3; P < 0.001] and by 12.9 after SDM skill development (95% CI 10 -15.8, P < 0.001), a moderate effect size. The level of involvement achieved by the risk communication aids was significantly increased by the subsequent introduction of the skill development workshops (7.7 increase in OPTION score, 95% CI 3.4-12; P < 0.001). The alternative sequence (skills followed by risk communication aids) did not achieve this effect. The use of most risk information formats increased after the provision of specific risk communication aids (P < 0.001). Clinicians using the risk communication tools perceived significantly higher patient and clinician agreement on treatment (P < 0.001), patient satisfaction with information (P < 0.01), clinician satisfaction with decision (P < 0.01) and general overall satisfaction with the consultation (P < 0.001) than those who were exposed to SDM skill development workshops.

CONCLUSIONS: These clinicians were able to acquire the skills to implement SDM competences and to use risk communication aids. Each intervention provided independent effects. Further progress towards greater patient involvement in health care decision making is possible, and skill development in this area should be incorporated into postgraduate professional development programmes.


In the setting of clinical medical education, feedback refers to information describing students' or house officers' performance in a given activity that is intended to guide their future performance in that same or in a related activity. It is a key step in the acquisition of clinical skills, yet feedback is often omitted or handled improperly in clinical training. This can result in important untoward consequences, some of which may extend beyond the training period. Once the nature of the feedback process is appreciated, however, especially the distinction between feedback and evaluation and the importance of focusing on the trainees' observable behaviors rather than on the trainees themselves, the educational benefit of feedback can be realized. This article presents guidelines for offering feedback that have been set forth in the literature of business administration, psychology, and education, adapted here for use by teachers and students of clinical medicine.


The author reviews definitions of competence and performance and provides a review of assessment methods used to assess learner competence and performance in the context of medical training. Methods for assessing clinical skills, including communication and counseling skills, are critically reviewed. The author offers a set of principles for enhancing the assessment and learning process.
The phrase “patient-centered care” is in vogue, but its meaning is poorly understood. This article describes patient-centered care, why it matters, and how policy makers can advance it in practice. Ultimately, patient-centered care is determined by the quality of interactions between patients and clinicians. The evidence shows that patient-centered care improves disease outcomes and quality of life, and that it is critical to addressing racial, ethnic, and socioeconomic disparities in health care and health outcomes. Policy makers need to look beyond such areas as health information technology to shape a coordinated and focused national policy in support of patient-centered care. This policy should help health professionals acquire and maintain skills related to patient-centered care, and it should encourage organizations to cultivate a culture of patient-centeredness.


The goal of patient-centered communication (PCC) is to help practitioners provide care that is concordant with the patient’s values, needs and preferences, and that allows patients to provide input and participate actively in decisions regarding their health and health care. PCC is widely endorsed as a central component of high-quality health care, but it is unclear what it is and how to measure it. PCC includes four communication domains: the patient’s perspective, the psychosocial context, shared understanding, and sharing power and responsibility. Problems in measuring PCC include lack of theoretical and conceptual clarity, unexamined assumptions, lack of adequate control for patient characteristics and social contexts, modest correlations between survey and observational measures, and overlap of PCC with other constructs. We outline problems in operationalizing PCC, choosing tools for assessing PCC, choosing data sources, identifying mediators of PCC, and clarifying outcomes of PCC. We propose nine areas for improvement: (1) developing theory-based operational definitions of PCC; (2) clarifying what is being measured; (3) accounting for the communication behaviors of each individual in the encounter as well as interactions among them; (4) accounting for context; (5) validating of instruments; (6) interpreting patient ratings of their physicians; (7) doing longitudinal studies; (8) examining pathways and mediators of links between PCC and outcomes; and (9) dealing with the complexity of the construct of PCC. We discuss the use of observational and survey measures, multi-method and mixed-method research, and standardized patients. The increasing influence of the PCC literature to guide medical education, licensure of clinicians, and assessments of quality provides a strong rationale for further clarification of these measurement issues.


In the context of serious illness, individuals usually rely on others to help them think and feel their way through difficult decisions. To help us to understand why, when, and how individuals involve trusted others in sharing information, deliberation, and decision making, we offer the concept of shared mind-ways in which new ideas and perspectives can emerge through the sharing of thoughts, feelings, perceptions, meanings, and intentions among 2 or
more people. We consider how shared mind manifests in relationships and organizations in general, building on studies of collaborative cognition, attunement, and sensemaking. Then, we explore how shared mind might be promoted through communication, when appropriate, and the implications of shared mind for decision making and patient autonomy. Next, we consider a continuum of patient-centered approaches to patient-clinician interactions. At one end of the continuum, an interactional approach promotes knowing the patient as a person, tailoring information, constructing preferences, achieving consensus, and promoting relational autonomy. At the other end, a transactional approach focuses on knowledge about the patient, information-as-commodity, negotiation, consent, and individual autonomy. Finally, we propose that autonomy and decision making should consider not only the individual perspectives of patients, their families, and members of the health care team, but also the perspectives that emerge from the interactions among them. By drawing attention to shared mind, clinicians can observe in what ways they can promote it through bidirectional sharing of information and engaging in shared deliberation.


This series of articles explores various ways of supporting staff who work in the fast-moving and ever-changing health service. In previous articles, John Fowler, an experienced nursing lecturer, author and consultant examined the importance of developing a supportive working culture and the role of preceptorship, mentoring and clinical supervision. This article examines how giving and receiving feedback can be a supportive experience.


**BACKGROUND:** Competency-based education (CBE) has emerged in the health professions to address criticisms of contemporary approaches to training. However, the literature has no clear, widely accepted definition of CBE that furthers innovation, debate, and scholarship in this area.

**AIM:** To systematically review CBE-related literature in order to identify key terms and constructs to inform the development of a useful working definition of CBE for medical education.

**METHODS:** We searched electronic databases and supplemented searches by using authors’ files, checking reference lists, contacting relevant organizations and conducting Internet searches. Screening was carried out by duplicate assessment, and disagreements were resolved by consensus. We included any English- or French-language sources that defined competency-based education. Data were analyzed qualitatively and summarized descriptively.

**RESULTS:** We identified 15,956 records for initial relevancy screening by title and abstract. The full text of 1,826 records was then retrieved and assessed further for relevance. A total of 173 records were analyzed. We identified 4 major themes (organizing framework, rationale, contrast with time, and implementing CBE) and 6 sub-themes (outcomes defined, curriculum of competencies, demonstrable, assessment, learner-centered and societal needs). From these themes, a new definition of CBE was synthesized.
CONCLUSION: This is the first comprehensive systematic review of the medical education literature related to CBE definitions. The themes and definition identified should be considered by educators to advance the field.


This literature review provides a detailed analysis of literature addressing coaching with particular focus on available literature from the UK. A definition and detailed description of coaching is provided, highlighting the differences between coaching and mentoring and the reasons for the increased application of coaching over recent years. Coaching is a developmental intervention that is increasingly being employed in organisations. Targeted development interventions such as coaching enable individuals to adjust to major changes in the rapidly evolving business environment. Coaching can help to support individuals in making the necessary steps to advance in their careers and perform at optimum levels in roles that require large step-changes in skills and responsibility. This detailed literature review documents the importance of coaching relationships and provides practical examples of how effective coaching can be established. This ranges from individual requirements to organizational needs. An extensive review of this area has revealed that there is limited empirical evidence available. Rather, practical examples and tool kits provided in the literature tend to be based on the author’s experience of delivering coaching programs and their personal and professional experience of coaching relationships.


This book provides a valuable guide to the development of mentor programs and the skills and activities involved in the coaching and mentoring process. Because of the overlapping definitions and interpretations of these terms the author uses the term ‘coach-mentoring’ throughout the publication.


This series of articles explores various ways of supporting staff who work in the fast-moving and ever-changing health service. In previous articles, John Fowler, an experienced nursing lecturer, author and consultant examined the importance of developing a supportive working culture and the role of preceptorship, mentoring and clinical supervision. This article examines how giving and receiving feedback can be a supportive experience.


An analysis of the concept of experiential learning indicates that it is the product of reflection upon experience, with the nature of the reflection and the quality of the experience, being significant to the overall learning. The outcomes of experiential learning appear to be
diverse; ranging from the acquisition of a new skill or personal development through to social consciousness-raising. A framework for experiential learning is produced which identifies factors that facilitate learning and those which act as barriers. The relationship between the facilitation of learning and coaching is identified.


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OBJECTIVE: There is a dearth of information on the extent to which diabetic patients receive care congruent with the chronic care model (CCM) and evidence-based behavioral counseling. This study evaluates a new instrument to fill this gap.

RESEARCH DESIGN AND METHODS: A heterogeneous sample of 363 type 2 diabetic patients completed the original Patient Assessment of Chronic Illness Care (PACIC), along with additional items that allowed it to be scored according to the “5As” (ask, advise, agree, assist, and arrange) model of behavioral counseling. We evaluated relationships between survey scores and patient characteristics, quality of diabetes care, and self-management.

RESULTS: Findings replicated those of the initial PACIC validation study but with a much larger sample of diabetic patients and more Latinos. Areas of CCM activities reported least often were goal setting/intervention tailoring and follow-up/coordination. The 5As scoring revealed that patients were least likely to receive assistance with problem solving and
arrangement of follow-up support. Few demographic or medical characteristics were related to PACIC or 5As scores, but survey scores were significantly related to quality of diabetes care received and level of physical activity.

CONCLUSIONS: The PACIC and the new 5As scoring method appear useful for diabetic patients. Its use is encouraged in future research and quality improvement studies.


BACKGROUND: An important barrier to the delivery of health behavior change interventions in primary care settings is the lack of an integrated screening and intervention approach that can cut across multiple risk factors and help clinicians and patients to address these risks in an efficient and productive manner.

METHODS: We review the evidence for interventions that separately address lack of physical activity, an unhealthy diet, obesity, cigarette smoking, and risky/harmful alcohol use, and evidence for interventions that address multiple behavioral risks drawn primarily from the cardiovascular and diabetes literature.

RESULTS: There is evidence for the efficacy of interventions to reduce smoking and risky/harmful alcohol use in unselected patients, and evidence for the efficacy of medium- to high-intensity dietary counseling by specially trained clinicians in high-risk patients. There is fair to good evidence for moderate, sustained weight loss in obese patients receiving high-intensity counseling, but insufficient evidence regarding weight loss interventions in non-obese adults. Evidence for the efficacy of physical activity interventions is limited. Large gaps remain in our knowledge about the efficacy of interventions to address multiple behavioral risk factors in primary care.

CONCLUSIONS: We derive several principles and strategies for delivering behavioral risk factor interventions in primary care from the research literature. These principles can be linked to the “5A’s” construct (assess, advise, agree, assist, and arrange-follow up) to provide a unifying conceptual framework for describing, delivering, and evaluating health behavioral counseling interventions in primary healthcare settings. We also provide recommendations for future research.


Learners value feedback highly, and valid feedback is based on observation. Deal with observable behaviours and be practical, timely, and concrete. The one to one relationship enables you to give feedback with sensitivity and in private. Begin by asking the learner to tell you what he or she feels confident of having done well and what he or she would like to improve. Follow up with your own observations of what was done well (be specific), and then outline one or two points that could help the student to improve.

Effective influencers diagnose before they influence. The article provides an overview of approaches and questions that savvy leaders use to identify obstacles and strategies for creating positive leverage.


Health services research consistently demonstrates a gap between research-based best clinical practice and what doctors actually do. Traditionally, the profession of medicine has behaved as if dissemination of research findings in peer-reviewed journals will eliminate this gap, even though professionals typically have less than 1 hour per week to read. This problem is complicated by the fact that physicians have not been trained generally to appraise published research, which is of variable quality in any event. Physicians interested in changing their practices also encounter organizational, peer group, and individual barriers at the same time as they face information overload and patient expectations. In a word, physicians’ abilities to manage information is overwhelmed. This article both summarizes initiatives to improve physicians’ information management through efforts to synthesize available evidence and describes the current evidence base of effectiveness and efficiency of dissemination and implementation strategies. We conclude that there is an imperfect evidence base to support decisions regarding strategies that are likely to be appropriate and effective under varying circumstances. Since this problem is compounded by the lack of a theoretical base for conceptualizing physician behavior change, we suggest exploring the applicability of behavioral theories to the understanding of professional behavior change. We also suggest exploring the use of theory-based process evaluations alongside randomized trials of dissemination and implementation strategies to further test theories and to explore causal mechanisms. Further research is required to explore determinants of provider behavior to better identify modifiable and non-modifiable effect modifiers, to develop methods of identifying barriers and facilitators to change, and to estimate the efficiency of dissemination and implementation strategies in the presence of different barriers and effect modifiers.


There are serious problems associated with the underuse, overuse, and misuse of health care. Part of the solution involves changing practicing physicians’ competence and performance, but this proves to be a difficult task. People differ widely in their views of how the behavior of physicians can be effectively changed. Some approaches focus on improving the knowledge, skills, or attitudes of professionals, whereas others believe in changing the social interaction and collaboration within teams or changing the organizational or political context. Some believe in self-motivation and regulation by those who need to change, whereas others emphasize external stimuli, pressure, or control. However, systematic reviews show that no current approach is superior for all purposes and target groups and that we may need them all, well integrated, to achieve effective improvements in patient care. Educational activities for professionals are not sufficient and should be combined with activities and measures at other levels. Those wishing to improve the competence and performance of physicians must be aware of the limitations of educational approaches and know how to integrate these with approaches that focus on teams, organizations, or the political or economic context. Teachers of physicians need to develop their knowledge and skills in these areas to be successful.

The author offers four principles are commonly used by the most successful coaches. • Establish a positive “team culture” with coaches and players committed to success • Communicate learning objectives and expectations • Provide timely and frequent feedback. • Remain fair and credible to all. The four critical principles are followed by successful coaches and resident educators in order to establish a positive and committed “team culture,” communicate learning objectives and expectations, provide timely feedback, and remain fair and credible to all.


In the workplace, the process of evaluating and discussing the performance of both employees and managers is referred to as feedback. The process generally involves a discussion of the individual’s strengths or weaknesses, with suggestions on how to improve upon weaknesses. Feedback aligns workplace behavior with the overall goals of a team or an organization. Although the ways in which work teams and organizations provide employee feedback vary greatly, most formalized systems include some sort of quantitative scale coupled with qualitative feedback. To help prepare students for providing and receiving qualitative feedback, the authors incorporate feedback assignments into their courses. This article proposes two feedback models and introduces four assignments that have successfully been implemented.


**BACKGROUND:** Effective chronic disease self-management among older adults is crucial for improved clinical outcomes. We assessed the relative importance of two dimensions of physician communication-provision of information (PCOM) and participatory decision-making (PDM)-for older patients’ diabetes self-management and glycemic control.

**METHODS:** We conducted a national cross-sectional survey among 1588 older community-dwelling adults with diabetes (response rate: 81%). Independent associations were examined between patients’ ratings of their physician’s PCOM and PDM with patients’ reported diabetes self-management (medication adherence, diet, exercise, blood glucose monitoring, and foot care), adjusting for patient sociodemographics, illness severity, and comorbidities. Among respondents for whom hemoglobin A1c (HbA1c) values were available (n=1233), the relationship was assessed between patient self-management and HbA1c values. RESULTS: In separate multivariate regressions, PCOM and PDM were each associated with overall diabetes self-management (p<.001) and with all self-management domains (p<.001 in all models), with the exception of PDM not being associated with medication adherence. In models with both PCOM and PDM, PCOM alone predicted medication adherence (p=.001) and foot care (p=.002). PDM alone was associated with exercise and blood glucose monitoring (both p<.001) and was a stronger independent predictor than PCOM of diet. Better patient ratings of their diabetes self-management were associated with lower HbA1c values (B= -.10, p=.005).

**CONCLUSION:** Among these older adults, both their diabetes providers’ provision of information and efforts to actively involve them in treatment decision-making were associated with better overall
diabetes self-management. Involving older patients in setting chronic disease goals and decision-making, however, appears to be especially important for self-care areas that demand more behaviorally complex lifestyle adjustments such as exercise, diet, and blood glucose monitoring.


With many factors converging, it is critical that nurse leaders have the knowledge and competency to develop outstanding relationships with registered nurses in order to retain them and thus improve patient outcomes. Senior nurse leaders of Methodist Le Bonheur Healthcare, a 7-hospital system based in Memphis is addressing these issues through a comprehensive leader development framework. Through organizational commitment and supported by a federal grant, a program that focuses on creation of individual development plans, provision of development education, and one-to-one on-site coaching has been implemented.


Motivational interviewing (MI) is a client-centered, directive therapeutic style to enhance readiness for change by helping clients explore and resolve ambivalence. An evolution of Rogers’s person-centered counseling approach, MI elicits the client’s own motivations for change. The rapidly growing evidence base for MI is summarized in a new meta-analysis of 72 clinical trials spanning a range of target problems. The average short-term between-group effect size of MI was 0.77, decreasing to 0.30 at follow-ups to one year. Observed effect sizes of MI were larger with ethnic minority populations, and when the practice of MI was not manual-guided. The highly variable effectiveness of MI across providers, populations, target problems, and settings suggests a need to understand and specify how MI exerts its effects. Progress toward a theory of MI is described, as is research on how clinicians develop proficiency in this method.


**OBJECTIVE:** The purpose of this study is to determine whether patient activation is a changing or changeable characteristic and to assess whether changes in activation also are accompanied by changes in health behavior.

**STUDY METHODS:** To obtain variability in activation and self-management behavior, a controlled trial with chronic disease patients randomized into either intervention or control conditions was employed. In addition, changes in activation that occurred in the total sample were also examined for the study period. Using Mplus growth models, activation latent growth classes were identified and used in the analysis to predict changes in health behaviors and health outcomes.

**DATA SOURCES:** Survey data from the 479 participants were collected at baseline, 6 weeks, and 6 months. Principal Findings. Positive change in activation is related to positive change in a variety of self-management behaviors. This is true even when the behavior in question is not being performed at baseline. When the behavior is already being performed at baseline, an increase in activation is related to maintaining a relatively high level of the
behavior over time. The impact of the intervention, however, was less clear, as the increase in activation in the intervention group was matched by nearly equal increases in the control group.

CONCLUSIONS: Results suggest that if activation is increased, a variety of improved behaviors will follow. The question still remains, however, as to what interventions will improve activation.


This article was written as part of a series in a column, The Coach’s Corner. Many clinician leaders are looked to by their colleagues for guidance and support on both personal and professional issues. Practicing discerning listening skills to determine what assistance may be needed can inform your practice as a mentor and/or coach to provide professional knowledge and experience to guide decision making or to help raise self-awareness and motivation. Mentoring is viewed as the transfer of knowledge or professional experience to another person to advance their understanding or achievement. However, sometimes a colleague needs someone who can stand apart from the issue and help them see it from a different perspective. They need to self-discover what’s right for them, reaching a conclusion based on their own values and beliefs. That’s when coaching is called for.


PURPOSE: Our purpose is to describe how coaches who are clinical faculty help in the developmental process of residents to become better physicians and to lead the improvement of quality and safety in the Dartmouth-Hitchcock Leadership Preventive Medicine Residency Program (DHLPMR).

METHOD: Using a semi-structured interview guide, eight coaches were interviewed and two focus groups were held with a total of nine residents. The qualitative data were content analysed to understand how both the coaches and residents perceive coaches’ work and their role.

RESULTS: The interviews with the coaches suggest that they take great pride in their work: they find it to be challenging and meaningful. The coaches use various skills and techniques—asking questions, listening deeply, observing the resident in action, offering encouragement and challenging the resident to think or act differently. The residents also perceive the work of the coach to help them progress on their learning journey. The role of the coach tends to go beyond coaching residents relative to improving an aspect of health care performance to creating the conditions for transformation and growth for the residents and the coaches.

CONCLUSION The DHLPMR program is a unique residency program that has the intention to foster the development of future physician leaders who have the ability to both practice medicine and improve the clinical practices in which they work. The coaches are a vital
ingredient in this program as they convey the residents/fellows on their leadership learning journey.


This case report presents specific steps taken to address potential patient safety problems, particularly those regarding collaboration between nurses and house staff at The George Washington University Hospital. Issues affecting patient care (e.g., lack of communication and teamwork) were identified through interviews, focus groups, and observations. The actions taken were team-building meetings that included a sensitivity session; coaching with nursing managers; and ground rules for nurse and physician collaboration. This report also describes the agenda for the team-building meetings, results, and lessons learned for implementation at other sites.


This article investigates the benefits of executive coaching for physicians and makes the case for integrating concepts and practices in the growing trend for executive coaching which has led to positive outcomes related to productivity, working relationships with direct reports and supervisors, teamwork, job satisfaction, working relationships with clients, cost reductions, etc.


This article presents a rationale for creating opportunities to seek out feedback as a strategy for self-improvement and to enhance performance.


A model for coaching in nursing is described. Criteria for selecting a coach are discussed. Competencies for a coach are recommended. In addition, guidelines for caching sessions are provided as well as an example of an action plan outline to help the coachee identify areas of desired growth and options for developing these areas.


**OBJECTIVE:** To evaluate the effects of a patient education workshop on nurses: (1) communication skills; (2) Knowledge of patient-centered model, patient education process, and sense of preparedness to provide patient education. Methods: Fourteen nurses attended a 2-day workshop on patient education based on a patient-centered model. Data on communication skills were collected by means of pre-/post-written dialogues and analyzed with the Roter Interaction Analysis System (RIAS). Data of nurses’ knowledge and sense of
preparedness were collected through a post questionnaire comprised of 5-point Likert scale items.

RESULTS: Post-dialogues showed an increase in patient talking (P < 0.001) and in patient-centered communication as indicated by the increase in Psychosocial exchanges (P = 0.003) and Process exchanges (P = 0.001). Nurses reported that the workshop increased “very much” their knowledge of the patient-centered model (mean = 4.19) and patient education process (mean = 4.69), and their sense of preparedness to provide patient education (P = 0.001).

CONCLUSIONS: Data suggest the efficacy of the workshop in developing patient-centered communication skills and improving nurses’ knowledge and preparedness to deliver patient education.

PRACTICE IMPLICATIONS: Trainings based on a patient-centered model and interactive learning methods should be implemented for nurses to improve their ability to deliver effective patient education.


This article examines the relationship between employees’ feedback-seeking behavior and the informal performance feedback they receive from their supervisors. The focus is on those situations in which the employee is performing poorly. The central thesis is that when employees suspect that they are performing poorly, they often use feedback-seeking strategies that tend to minimize the amount of negative performance feedback they receive. Processes operating on both sides of the supervisor-employee interaction are identified as likely contributors to this effect. For the employee, these processes are rooted in a deep-seated motivation to maintain a positive self esteem, and for the supervisor, they are rooted in an underlying reluctance about giving negative performance feedback.


This article offers coaching approaches to provide disruptive physicians with a clear picture of themselves so they can better understand how their behaviors affect others.


Performance feedback is one of a number of strategies used to improve clinical practice among students and clinicians. Objectives of this paper were to examine conceptual underpinnings and essential components for audit and feedback strategies, to assess the extent to which recently published audit and feedback interventions include these components and to recommend future directions for feedback to improve its educational and behavioral objectives based on the actionable impact. Methods feedback model, we examined the presence of four theoretical constructs - timeliness, individualization, lack of punitiveness and customizability - in studies published during 2009-2010 which included a
feedback intervention. There was wide variation in the definition, implementation and outcomes of ‘feedback’ interventions, making it difficult to compare across studies. None of the studies we reviewed included all of the components of the actionable feedback model. Conclusions reported to date, even when results are positive, often fail to include concepts of behavior change. This may partially explain the large variation in approaches and in results of such interventions and presents major challenges for replicating any given intervention. If feedback processes are to be successfully used and disseminated and implemented widely, some standardization and certainly more clarity is needed in the specific action steps taken to apply behavioral theory to practice.


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Addressing the most common workplace relationship challenges, this manual shows how to use the principles of nonviolent communication to improve the workplace atmosphere. Offering practical tools that match recognizable work scenarios, this guide can help all employees positively affect their work relationships and company culture, regardless of their position. This handbook displays proven communication skills for effectively handling difficult conversations, reducing workplace conflict and stress, improving individual and team productivity, having more effective meetings, and giving and receiving meaningful feedback, thereby creating a more enjoyable work environment.


This paper explores the relationship between leadership style as operationalized by transformational /transactional leadership (Bass, 1985) and feedback-seeking behavior. Participants (n = 132) were presented with a vignette describing either a transformational or a transactional leader. Leadership style (transformational leader) was significantly related to higher feedback-seeking intentions. Further, controlling for manipulated leadership style, participants' perceptions of leader consideration behaviors resulted in higher feedback-seeking intentions. These findings suggest that not only does exposure to a certain leader affect feedback-seeking behavior, but also perceptions of certain characteristics of a leader's behavior are important. These findings explain one potential mechanism through which transformational leaders might affect the development of their subordinates and raises interesting implications for leadership coaching.


This study investigated factors that influence managers’ conceptions and subordinates’ perceptions of effective feedback. A social rules perspective was used to operationalize male and female managers’ conceptions of effective negative feedback. In the first study, 68 male and female managers identified their optimal strategies for providing feedback to subordinates. Male and female managers endorsed different goals and tactics for giving negative feedback, particularly in terms of levels of participation and directness. In the second study, 116 male and female subordinates evaluated the comparative effectiveness and difficulty of these and other standard approaches to feedback. The female manager strategy was evaluated by both men and women as generally more task and relationship effective but not more difficult to enact.


Growing enthusiasm about patient-centered medical homes, fueled by the Patient Protection and Affordable Care Act’s emphasis on improved primary care, has intensified interest in how to deliver patient-centered care. Essential to the delivery of such care are patient-centered communication skills. These skills have a positive impact on patient satisfaction,
treatment adherence, and self-management. They can be effectively taught at all levels of medical education and to practicing physicians. Yet most physicians receive limited training in communication skills. Policy makers and stakeholders can leverage training grants, payment incentives, certification requirements, and other mechanisms to develop and reward effective patient-centered communication.


In May 1999, 21 leaders and representatives from major medical education and professional organizations attended an invitational conference jointly sponsored by the Bayer Institute for Health Care Communication and the Fetzer INSTITUTE: The participants focused on delineating a coherent set of essential elements in physician-patient communication to: (1) facilitate the development, implementation, and evaluation of communication-oriented curricula in medical education and (2) inform the development of specific standards in this domain. Since the group included architects and representatives of five currently used models of doctor-patient communication, participants agreed that the goals might best be achieved through review and synthesis of the models. Presentations about the five models encompassed their research base, overarching views of the medical encounter, and current applications. All attendees participated in discussion of the models and common elements. Written proceedings generated during the conference were posted on an electronic listserv for review and comment by the entire group. A three-person writing committee synthesized suggestions, resolved questions, and posted a succession of drafts on a listserv. The current document was circulated to the entire group for final approval before it was submitted for publication. The group identified seven essential sets of communication tasks: (1) build the doctor-patient relationship; (2) open the discussion; (3) gather information; (4) understand the patient’s perspective; (5) share information; (6) reach agreement on problems and plans; and (7) provide closure. These broadly supported elements provide a useful framework for communication-oriented curricula and standards.


**OBJECTIVE:** Interpersonal and communication skills have been identified as a core competency that must be demonstrated by physicians. We developed and tested a tool that can be used by patients to assess the interpersonal and communication skills of physicians-in-training and physicians-in-practice.

**METHODS:** We began by engaging in a systematic scale development process to obtain a psychometrically sound Communication Assessment Tool (CAT). This process yielded a 15-item instrument that is written at the fourth grade reading level and employs a five-point response scale, with 5=excellent. Fourteen items focus on the physician and one targets the staff. Pilot testing established that the CAT differentiates between physicians who rated high or low on a separate satisfaction scale. We conducted a field test with physicians and patients from a variety of specialties and regions within the US to assess the feasibility of using the CAT in everyday practice.

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RESULTS: Thirty-eight physicians and 950 patients (25 patients per physician) participated in the field test. The average patient-reported mean score per physician was 4.68 across all CAT items (S.D.=0.54, range 3.97-4.95). The average proportion of excellent scores was 76.3% (S.D.=11.1, range 45.7-95.1%). Overall scale reliability was high (Cronbach’s alpha=0.96); alpha coefficients were uniformly high when reliability was examined per doctor.

CONCLUSION: The CAT is a reliable and valid instrument for measuring patient perceptions of physician performance in the area of interpersonal and communication skills. The field test demonstrated that the CAT can be successfully completed by both physicians and patients across clinical specialties. Reporting the proportion of “excellent” ratings given by patients is more useful than summarizing scores via means, which are highly skewed.

PRACTICE IMPLICATIONS: Specialty boards, residency programs, medical schools, and practice plans may find the CAT valuable for both collecting information and providing feedback about interpersonal and communication skills.


Estimates for leadership skills predict a shift from crisis management to coaching processes—a shift from 2% coaching to 70% leadership time spent in coaching. Conversely, time spent in crisis management is expected to decrease from 90% to less than 10%. The role of the leader is necessarily shifting from decision maker to facilitator, from traffic cop to role model, from boss to coach. Effective coaching can affect both the individuals and the organization in several ways. This includes gaining insight into another’s feelings and behaviors, identifying development needs, confronting performance issues in an organized way, recognizing the contributions of others and improving employee satisfaction.


The authors reflect upon the research studies that focus on feedback process in medical education and draw upon their own work in reconceptualizing feedback, which positions learners as active in seeking, generating and using feedback to change their task performance.


Research regarding the development of healthcare leadership competencies is widely available. However, minimal research has been published regarding the development of physician leadership competencies, despite growing recognition in recent years of the important need for effective physician leadership. Using data from an electronically distributed, self-administered survey, the authors examined the perceptions held by 110 physician leaders, physician educators, and medical students regarding the extent to which
nine competencies are important for effective physician leadership, ten activities are indicative of physician leadership, and seven methods are effective for the development of physician leadership competencies. Results indicated that “interpersonal and communication skills” and “professional ethics and social responsibility” are perceived as the most important competencies for effective physician leadership. Furthermore, respondents believe “influencing peers to adopt new approaches in medicine” and “administrative responsibility in a healthcare organization” are the activities most indicative of effective physician leadership. Finally, respondents perceive “coaching or mentoring from an experienced leader” and “on-job experience (e.g., a management position)” as the most effective methods for developing physician leadership competencies. The implications of these findings for the education and development of physician leaders are discussed.


Feedback is a vital part of education and training which, if carried out well, helps motivate and develop learners’ knowledge, skills and behaviors. It helps learners to maximize their potential and professional development at different stages of training, raise their awareness of strengths and areas for improvement, and identify actions to be taken to improve performance.


**OBJECTIVE:** To investigate the literature for evidence that workplace based assessment affects doctors’ education and performance.

**DESIGN:** Systematic review.

**DATA SOURCES:** The primary data sources were the databases Journals@Ovid, Medline, Embase, CINAHL, PsycINFO, and ERIC. Evidence based reviews (Bandolier, Cochrane Library, DARE, HTA Database, and NHS EED) were accessed and searched via the Health Information Resources website. Reference lists of relevant studies and bibliographies of review articles were also searched. Review methods Studies of any design that attempted to evaluate either the educational impact of workplace based assessment, or the effect of workplace based assessment on doctors’ performance, were included. Studies were excluded if the sampled population was non-medical or the study was performed with medical students. Review articles, commentaries, and letters were also excluded. The final exclusion criterion was the use of simulated patients or models rather than real life clinical encounters.

**RESULTS:** Sixteen studies were included. Fifteen of these were non-comparative descriptive or observational studies; the other was a randomized controlled trial. Study quality was mixed. Eight studies examined multisource feedback with mixed results; most doctors felt that multisource feedback had educational value, although the evidence for practice change was conflicting. Some junior doctors and surgeons displayed little willingness to change in response to multisource feedback, whereas family physicians might be more prepared to initiate change. Performance changes were more likely to occur when feedback was credible and accurate or when coaching was provided to help subjects identify their strengths and weaknesses. Four studies examined the mini-clinical evaluation exercise, one looked at direct observation of procedural skills, and three were concerned with multiple assessment.
methods: all these studies reported positive results for the educational impact of workplace based assessment tools. However, there was no objective evidence of improved performance with these tools.

CONCLUSIONS: Considering the emphasis placed on workplace based assessment as a method of formative performance assessment, there are few published articles exploring its impact on doctors’ education and performance. This review shows that multisource feedback can lead to performance improvement, although individual factors, the context of the feedback, and the presence of facilitation have a profound effect on the response. There is no evidence that alternative workplace based assessment tools (mini-clinical evaluation exercise, direct observation of procedural skills, and case based discussion) lead to improvement in performance, although subjective reports on their educational impact are positive.


This article presents a model program for managing problem employees that includes a description of the basic types of problem employees and employee problems, as well as practical recommendations for: (1) selection and screening, (2) education and training, (3) coaching and counseling, (4) discipline, (5) psychological fitness-for-duty evaluations, (6) mental health services, (7) termination, and (8) leadership and administrative strategies. Throughout, the emphasis on balancing the need for order and productivity in the workplace with fairness and concern for employee health and well-being.


Unexpected findings are often the spark for new discoveries and theories. A puzzle emerged from a series of unanticipated findings over 3 decades, indicating that for problem drinkers (a) relatively brief interventions can trigger significant change, (b) increasing the intensity of treatment does not consistently improve outcome, (c) therapist empathy can be a potent predictor of client change, and (d) a single empathic counseling session can substantially enhance the outcome of subsequent treatment. These phenomena are considered in light of other findings in the addictions-treatment-outcome literature. There is, at present, no cogent explanation for the efficacy of brief interventions. An ancient construct is explored as one possible factor in how some brief encounters may exert large effects in human change.


**BACKGROUND:** In the 26 years since it was first introduced in this journal, motivational interviewing (MI) has become confused with various other ideas and approaches, owing in part to its rapid international diffusion.

**METHODS:** Based on confusions that have arisen in publications and presentations regarding MI, the authors compiled a list of 10 concepts and procedures with which MI should not be addled.

**RESULTS:** This article discusses 10 things that MI is not: (1) the transtheoretical model of change; (2) a way of tricking people into doing what you want them to do; (3) a technique;
(4) decisional balance; (5) assessment feedback; (6) cognitive-behavior therapy; (7) client-centered therapy; (8) easy to learn; (9) practice as usual; and (10) a panacea.

**CONCLUSION**: Clarity about what does (and does not) constitute MI promotes quality assurance in scientific research, clinical practice, and training.


The widely disseminated clinical method of motivational interviewing (MI) arose through a convergence of science and practice. Beyond a large base of clinical trials, advances have been made toward “looking under the hood” of MI to understand the underlying mechanisms by which it affects behavior change. Such specification of outcome-relevant aspects of practice is vital to theory development and can inform both treatment delivery and clinical training. An emergent theory of MI is proposed that emphasizes two specific active components: a relational component focused on empathy and the interpersonal spirit of MI, and a technical component involving the differential evocation and reinforcement of client change talk. A resulting causal chain model links therapist training, therapist and client responses during treatment sessions, and posttreatment outcomes.


The Evaluating Methods for Motivational Enhancement Education trial evaluated methods for learning motivational interviewing (MI). Licensed substance abuse professionals (N = 140) were randomized to 5 training conditions: (a) clinical workshop only; (b) workshop plus practice feedback; (c) workshop plus individual coaching sessions; (d) workshop, feedback, and coaching; or (e) a waiting list control group of self-guided training. Audiotaped practice samples were analyzed at baseline, posttraining, and 4, 8, and 12 months later. Relative to controls, the 4 trained groups showed larger gains in proficiency. Coaching and/or feedback also increased posttraining proficiency. After delayed training, the waiting list group showed modest gains in proficiency. Posttraining proficiency was generally well maintained throughout follow-up. Clinician self-reports of MI skillfulness were unrelated to proficiency levels in observed practice.


This report presents reliability, validity and sensitivity indices for the Motivational Interviewing Treatment Integrity (MITI) scale. Factor analysis of MI treatment sessions coded with the Motivational Interviewing Skills Code (MISC) was used to derive 10 elements of MI practice, forming the MITI. Canonical correlation revealed that the MITI captured 59% of the variability in the MISC. Reliability estimates for the MITI were derived using three masked, independent coders. Intra-class coefficients ranged from .5 to .9 and were generally in the good to excellent range. Comparison of MITI scores before and after MI workshops indicate good sensitivity for detecting improvement in clinical practice as
result of training. Implications for the use of this instrument in research and supervision are discussed.


Although many studies have shown that motivational interviewing (MI) is effective in reducing problem behaviors, few have investigated purported causal mechanisms. Therapist interpersonal skills have been proposed as an influence on client involvement during MI sessions and as a necessary precursor to client commitment language. Using the Motivational Interviewing Skills Code (MISC; Version 1.0) rating system, the authors investigated 103 unique MI sessions for substance abuse and found that therapist interpersonal skills were positively associated with client involvement as defined by cooperation, disclosure and expression of affect. An unexpected finding indicated that behaviors inconsistent with MI enhanced the impact of therapist interpersonal skills upon client involvement. Drawbacks to the study include a potential sampling bias and uneven reliability of the variables measured.


The preceptors and leadership team on a busy acute care general medical unit collaborated on a temporary plan to provide clinical support for 38 nurses who had been hired during the year. A pilot role was created and designated “unit coach.” Each coach questioned and prompted reflective practice in building confidence and critical thinking.


Giving students effective feedback is the mainstay of ensuring that students’ developing clinical practice reaches competency. Without knowing where and how to change, students will not be able to progress in their clinical practice and, just as importantly, will become disillusioned. Delivering effective feedback by tutors requires thought, adequate preparation and appropriate training. The development of these guidelines encourages our diverse clinical tutors to concentrate on the main principles of delivering such feedback and provides examples of how to go about it.
BACKGROUND: Traditional assessment has improved significantly over the past 50 years. A number of new testing methods are now in place, the computer is improving both the fidelity and efficiency of examinations, and the psychometric principles on which assessment rests are more sophisticated than ever.

AIM: There is growing interest in quality improvement and there are increasing demands for public accountability. This has shifted the focus of testing from education to work. The purpose of this paper is to describe the assessment of work.

DISCUSSION: In contrast to traditional assessment, there are no ‘methods’ for the evaluation of work because the content and difficulty of the examination are not controlled in any fashion. Instead it is a matter of identifying the basis for the judgments (outcomes, process, or volume), deciding how the data will be gathered (practice records, administrative databases, diaries/logs, or observation), and avoiding threats to validity and reliability (patient mix, patient complexity, attribution, and numbers of patients).

FUTURE DIRECTIONS: Overall, the assessment of doctors’ performance at work is in its infancy and much research and development is needed. Nonetheless, it is being used increasingly in programmes of continuous quality improvement and accountability. It is critical that refinements occur quickly to ensure that patients receive the highest quality of care and that doctors are treated fairly and provided with the information they need to guide their professional development.


Feedback is an important part of a student's clinical education. Without appropriate feedback, students may make incorrect assumptions about clinical competence, and they have little guidance for improvement of future performances. Feedback that is specific, process-oriented, frequent, immediate, and presented in a manner that facilitates two-way communication with the student provides the greatest benefits. Feedback should be more focused on providing information for future improvements, rather than judging the quality of a performance.


OBJECTIVE: To evaluate the effectiveness of a training program for physician-delivered nutrition counseling, alone and in combination with an office-support program, on dietary fat intake, weight, and blood low-density lipoprotein cholesterol levels in patients with hyperlipidemia.

PARTICIPANTS AND METHODS: Forty-five primary care internists at the Fallon Community Health Plan, a central Massachusetts health maintenance organization, were
randomized by site into 3 groups: (1) usual care; (2) physician nutrition counseling training; and (3) physician nutrition counseling training plus an office-support program. Eleven hundred sixty-two of their patients with blood total cholesterol levels in the highest 25th percentile, having previously scheduled physician visits, were recruited. Physicians in groups 2 and 3 attended a 3-hour training program on the use of brief patient-centered interactive counseling and the use of an office-support program that included in-office prompts, algorithms, and simple dietary assessment tools. Primary outcome measures included change at 1-year of follow-up in percentage of energy intake from saturated fat; weight; and blood low-density lipoprotein cholesterol levels.

RESULTS: Improvement was seen in all 3 primary outcome measures, but was limited to patients in group 3. Compared with group 1, patients in group 3 had average reductions of 1.1 percentage points in percent of energy from saturated fat (a 10.3% decrease) (P = .01); a reduction in weight of 2.3 kg (P<.001); and a decrease of 0.10 mmol/L (3.8 mg/dL) in low-density lipoprotein cholesterol level (P = .10). Average time for the initial counseling intervention in group 3 was 8.2 minutes, 5.5 minutes more than in the control group.

CONCLUSION: Brief supported physician nutrition counseling can produce beneficial changes in diet, weight, and blood lipids.


BACKGROUND: There is a need for primary care providers to have brief effective methods to intervene with high-risk drinkers during a regular outpatient visit.

OBJECTIVE: To determine whether brief physician- and nurse practitioner-delivered counseling intervention is efficacious as part of routine primary care in reducing alcohol consumption by high-risk drinkers.

METHODS: Academic medical center-affiliated primary care practice sites were randomized to special intervention or to usual care. From a screened population of 9772 patients seeking routine medical care with their primary care providers, 530 high-risk drinkers were entered into the study. Special intervention included training providers in a brief (5- to 10-minute) patient-centered counseling intervention, and an office support system that screened patients, cued providers to intervene, and made patient education materials available. The primary outcome measures were change in alcohol use from baseline to 6 months as measured by weekly alcohol consumption and frequency of binge drinking episodes.

RESULTS: Participants in the special intervention and usual care groups were similar on important background variables and potential confounders except that special intervention participants had significantly higher baseline levels of alcohol usage (P = .01). At 6-month follow-up, in the 91% of the cohort who provided follow-up information, alcohol consumption was significantly reduced when adjusted for age, sex, and baseline alcohol usage (special intervention, -5.8 drinks per week; usual care, -3.4 drinks per week; P = .001).

CONCLUSIONS: This study provides evidence that screening and very brief (5- to 10-minute) advice and counseling delivered by a physician or nurse practitioner as part of routine primary care significantly reduces alcohol consumption by high-risk drinkers.

BACKGROUND: We examined the effect of a 3-hr training program on physicians’ lipid intervention knowledge, attitudes, and skills. The program teaches physicians skills to conduct a brief dietary risk assessment and provide patient-centered counseling to enable patients with elevated lipids to change their dietary patterns.

METHOD: The training is part of a randomized trial of lipid-lowering interventions, the Worcester Area Trial for Counseling in Hyperlipidemia. Primary care internists practicing in a health maintenance organization (HMO) were assessed, before and after training using questionnaires and audiotapes to document changes in knowledge about diet, attitudes about intervention, reported nutrition intervention practices, and counseling and assessment skills. Physicians also rated the value that they thought the training program had to them.

RESULTS: After completion of the program the physicians’ use of dietary counseling steps, as assessed by blinded evaluation of audiotaped physician-patient interactions, significantly increased (mean pre = 5.4, mean post = 9.2; t = 9.9; P < or = 0.001). In this regard, there were instances in the use of 7 of the 14 specific counseling steps. Physicians also demonstrated increases in self-perceived preparedness as measured by a 5-point scale (mean pre = 3.2, mean post = 4.0; t = 4.25; P < 0.001), confidence in having an effect (mean pre = 3.3, mean post = 3.9; t = 3.16; P < 0.01), perception that materials were available to aid intervention (mean pre = 2.7, mean post = 4.0; t = 5.29; P < 0.001), and perception that they have access to a nutritionist (mean pre = 3.5, mean post = 4.0; t = 2.63; P < 0.01). They rated the value of the program between very good and excellent.

CONCLUSION: Results of this 3-hr educational program indicate that physicians in an HMO are responsive to the teaching of specialized skills deemed important for promoting health behavior change in their patients.


A training module that provides an overview and skill set based on the belief that coaching and feedback is a critical skill for all employees. The author provides principles, guidelines and skills that are applicable for every individual within an organization that is responsible for elevating the organization to the next level.


A training module that provides an overview and skill set for giving and receiving positive and constructive feedback.


The feedback sandwich technique-make positive comments; provide critique; end with positive comments-is commonly recommended to feedback givers despite scant evidence of its efficacy. These two studies (N = 20; N = 350) of written peer feedback with third-year medical students on clinical patient note-writing assignments indicate that students
think feedback sandwiches positively impact subsequent performance when there is no
evidence that they do. The effort necessary to produce feedback sandwiches and students'
unwarranted confidence in their performance impact have implications for teaching about
how to give feedback.


Modifying patients’ sedentary lifestyle, a risk factor for many chronic diseases, is a challenge
to health professionals. Although physicians can play a vital role in promoting physical
activity among sedentary patients, the prevalence of physician-based exercise counseling is
low. This paper presents a review of studies that have targeted physicians as agents of
behavior change. Changing sedentary behavior is more likely to be effective when the
intervention is grounded in theory. This paper outlines an integration of two theoretical
models that have potential for enhancing behavior change, and it describes specific
techniques for physicians interested in promoting a more active lifestyle among their
patients.


Healthcare delivery is evolving from individual, autonomous practice to collaborative team
practice. However, barriers such as professional autonomy, time constraints and the
perception of error as failure preclude learning behaviors that can facilitate organizational
learning and improvement. Although experimentation, engaging in questions and feedback,
discussing errors and reflecting on results can facilitate learning and promote effective
performance, the cultural barriers within healthcare can prevent or inhibit this type of
behavior among teams. At the University Health Network's Centre for Innovation in
Complex Care, we realize the need for a tool that facilitates learning behavior and is sensitive
to the risk-averse nature of the clinical environment. The vehicle for the
Team Feedback Tool is a web-based application called Rypple (www.rypple.com), which
allows team members to provide anonymous, rapid-fire feedback on team processes and
performance. Rypple facilitates communication, elicits feedback and provokes discussion.
The process enables follow-up face-to-face team discussions and encourages teams to create
actionable solutions for incremental changes to enhance team health and performance. The
Team Feedback Tool was implemented and piloted in general internal medicine at the
University Health Network's Toronto General Hospital from early May 2009 to July 2009 to
address the issues of teamwork and learning behavior in the clinical environment. This article
explores the opportunities and barriers associated with the implementation of the
Team Feedback Tool.

Pollak KI. (2011). Incorporating MI Techniques into physician counseling. Patient Education
and Counseling, 84;1-2.

Given physicians’ role in encouraging patients to change, there is a trend for physicians to
learn MI techniques to make their counseling more efficient and effective. Studies provide
evidence that providers can learn MI techniques, even if they never achieve the gold standard. These small changes in communication might make the difference in patients quitting smoking, losing weight, or adhering to their medication regimen. A final positive outcome of physicians learning to counsel well is that they likely will see positive results when they counsel effectively. Seeing patients improve will increase physician outcome expectations for their counseling, which in turn, should promote more effective counseling of their patients in the future.


Effective brief interventions in routine clinical care have enormous potential to improve public health. Adaptations of motivational interviewing are generally more effective in changing single behaviours than no or minimal interventions, and they are usually as effective as more intensive alternatives. Helping patients change health threatening behaviour could be a routine component of most healthcare consultations. Given the scale of potential health gains, pressure is increasing to do more of this work. Enhancing motivation and encouraging change is a complex task that demands skillful consulting, and practitioners might benefit from refining their existing skills, particularly in the use of a guiding style. Patients deserve a sensitive response to difficult decisions about behaviour change. At the very least, we should be sure that we are doing no harm with our well intentioned interventions aimed at changing their behaviour.


Communication is a key skill of modern nursing practice, yet often it is an area in which nurses fail. Self-awareness exercises can help us to improve our communication skills and enhance healthcare delivery.


OBJECTIVE: To promote monthly interpersonal skill communication role-play and coaching for front-office staff.
METHOD: For 15 min a month, during staff meetings, healthcare staff such as receptionists and medical assistants should participate in communication skill coaching. Participants should discuss a recurring communication challenge (e.g., patients irritated by repeated requests for health histories), role-play options for communication, and receive feedback.
RESULT: Interpersonal communication skills such as acknowledging the concerns of others are acquired slowly. Repeated practice and supportive feedback increase the likelihood that these skills will be valued and mastered.
CONCLUSION: Research shows communication skills develop when they are modeled and role-played frequently and are less likely to develop with occasional interventions.
PRACTICE IMPLICATION: Health care professionals should devote time to role-playing interaction with patients for brief intervals at least monthly. Staff should give one another feedback on the best options for managing challenging communication situations.


BACKGROUND: Motivational interviewing has been shown to be broadly usable in a scientific setting in the management of behavioural problems and diseases. However, data concerning implementation and aspects regarding the use of motivational interviewing in general practice is missing.

AIM: To evaluate GPs’ conception of motivational interviewing in terms of methods, adherence to and aspects of its use in general practice after a course.

STUDY DESIGN: In a randomised controlled trial concerning intensive treatment of newly diagnosed patients with type 2 diabetes detected by screening, the GPs were randomised to a course in motivational interviewing or not. The study also included a third group of GPs outside the randomised controlled trial, who had 2 years previously received a similar course in motivational interviewing.

SETTING: General practice in Denmark.

METHOD: The intervention consisted of a 1.5-day residential course in motivational interviewing with 0.5-day follow-ups, twice during the first year. Questionnaire data from GPs were obtained.

RESULTS: We obtained a 100% response-rate from the GPs in all three groups. The GPs trained in motivational interviewing adhered statistically significantly more to the methods than did the control group. More than 95% of the GPs receiving the course stated that they had used the specific methods in general practice.

CONCLUSION: A course in motivational interviewing seems to influence GPs professional behaviour. Based on self-reported questionnaires, this study shows that the GPs after a course in motivational interviewing seemed to change their professional behaviour in daily practice using motivational interviewing compared with the control group. GPs evaluated motivational interviewing to be more effective than ‘traditional advice giving’. Furthermore, GPs stated that the method was not more time consuming than ‘traditional advice giving’.


OBJECTIVE: To examine whether training GPs in motivational interviewing (MI) can improve type 2 diabetic patients’ (1) understanding of diabetes, (2) beliefs regarding prevention and treatment, and (3) motivation for behaviour change.

METHODS: A randomized controlled trial including 65 GPs and 265 type 2 diabetic patients. The GPs were randomized in two groups, one with and one without MI training. Both groups received training in target-driven intensive treatment of type 2 diabetic patients.
The intervention was a 1(1/2)-day residential course in MI with (1/2)-day follow-up twice during the first year. The patient data stemmed from previously validated questionnaires.

MAIN OUTCOME MEASURES: The Health Care Climates Questionnaire assesses the patient-doctor relationship and type of counselling. The Treatment Self-Regulation Questionnaire assesses the degree to which behaviour tends to be self-determined. The Diabetes Illness Representation Questionnaire assesses beliefs and understanding of type 2 diabetes. The Summary of Diabetes Self Care Activities assesses the extent of various self-care activities related to type 2 diabetes.

RESULTS: The response rate to our questionnaires was 87%. Patients in the intervention group were significantly more autonomous and motivated in their inclination to change behaviour after one year compared with the patients from the control group. Patients in the intervention group were also significantly more conscious of the importance of controlling their diabetes, and had a significantly better understanding of the possibility of preventing complications.

CONCLUSION: MI improved type 2 patients’ understanding of diabetes, their beliefs regarding treatment aspects, their contemplation on and motivation for behaviour change. Whether our results can be sustained long term and are clinically relevant in terms of changes in risk profile advocates further research.


BACKGROUND: Motivational Interviewing is a well-known, scientifically tested method of counselling clients developed by Miller and Rollnick and viewed as a useful intervention strategy in the treatment of lifestyle problems and disease. AIM: To evaluate the effectiveness of motivational interviewing in different areas of disease and to identify factors shaping outcomes.

DESIGN OF STUDY: A systematic review and meta-analysis of randomised controlled trials using motivational interviewing as the intervention.

METHOD: After selection criteria a systematic literature search in 16 databases produced 72 randomised controlled trials the first of which was published in 1991. A quality assessment was made with a validated scale. A meta-analysis was performed as a generic inverse variance meta-analysis.

RESULTS: Meta-analysis showed a significant effect (95% confidence interval) for motivational interviewing for combined effect estimates for body mass index, total blood cholesterol, systolic blood pressure, blood alcohol concentration and standard ethanol content, while combined effect estimates for cigarettes per day and for HbA(1c) were not significant. Motivational interviewing had a significant and clinically relevant effect in approximately three out of four studies, with an equal effect on physiological (72%) and psychological (75%) diseases. Psychologists and physicians obtained an effect in approximately 80% of the studies, while other healthcare providers obtained an effect in 46% of the studies. When using motivational interviewing in brief encounters of 15 minutes, 64% of the studies showed an effect. More than one encounter with the patient ensures the effectiveness of motivational interviewing.

CONCLUSION: Motivational interviewing in a scientific setting outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases.
scale studies are now needed to prove that motivational interviewing can be implemented into daily clinical work in primary and secondary health care.


This study examined the effectiveness of training community mental health therapists in motivational interviewing (MI) adapted to treat clients with co-occurring disorders. Ten therapists with high caseloads of culturally diverse clients in two different community mental health settings fulfilled all study requirements. MI training consisted of a two-day didactic and experiential workshop followed by eight biweekly small group supervision (coaching) sessions. Using an interrupted time series design, 156 randomly selected therapy sessions involving 28 clients were coded for assessment of therapist fidelity to MI at multiple points in time, both pre- and post-training. Employing hierarchical linear modeling analysis, significant improvement in MI skill was observed after training on five of six key therapist ratings, and on the sole client rating (client change talk) that was examined. Importantly, the present study demonstrates training-related proficiency in motivational interviewing using: (a) a representative sample of mental health therapists from the community; (b) a protocol emphasizing adherence to a mental health treatment regimen as well as management of substance use behavior for clients with co-occurring disorders; (c) repeated random observations of therapy sessions; (d) measurement of training-related changes in clinician skills and self motivational statements by clients. Findings of this effectiveness study compared favorably with efficacy literature on MI training.


**INTRODUCTION:** Few studies have examined how peer coaching is an effective educational and development technique in contexts outside the classroom. This research focused on peer coaching as a platform to study the process of professional development for physicians. The purpose was to identify perceived benefits coaches received from a coaching encounter and how this relates to their own process of professional development.

**METHODS:** Critical incident interviews with 13 physician coaches were conducted and tape recorded. Themes were identified using a thematic analysis technique.

**RESULTS:** Themes emerged clustering around two distinct benefit orientations. Group 1, reflection and teaching coaches, tended to focus on others and discuss how positively they experienced the encounter. Group 2, personal learning and change coaches, expressed benefits along more personal lines.

**DISCUSSION:** Peer coaching contributes to physicians’ professional development by encouraging reflection time and learning. Peer coaching affords positive impact to those who coach in addition to those who receive the coaching. The two clusters of benefits support the performance, learning, and development theory in that there are multiple modes to describe adult growth and development. Programs of this type should be considered in medical faculty development activities associated with medical education.
BACKGROUND: Giving feedback is a core element of medical education, one that is gaining attention but with a thin evidence base to guide medical educators. This review provides a definition of feedback and its purpose, selectively reviews the literature regarding educators’ and learners’ attitudes toward feedback, and provides an algorithm for giving feedback.

DISCUSSION: The authors discuss the parallels between giving feedback and breaking bad news, emphasizing the importance of titrating the amount of information given, attending to affect, and making a plan for next steps. Special considerations for giving feedback in palliative care are highlighted, including the effect of heightened emotion in the clinical encounter and the difficulties of giving feedback about communication skills.


OBJECTIVE: Feedback is important in clinical education. However, the medical education literature provides no consensual definition of feedback. The aim of this study is to propose a consensual, research based, operational definition of feedback in clinical education. An operational definition is needed for educational practice and teacher training, and for research into the effectiveness of different types of feedback.

METHODS: A literature search about definitions of feedback was performed in general sources, metaanalyses and literature reviews in the social sciences and other fields. Feedback definitions given from 1995 to 2006 in the medical education literature are also reviewed.

RESULTS: Three underlying concepts were found, defining feedback as information; as reaction, including information, and as a cycle, including both information and reaction. In most medical education and social science literature, feedback is usually conceptualized as information only. Comparison of feedback definitions in medical education reveals at least 9 different features. The following operational definition is proposed. Feedback is: Specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee’s performance.

CONCLUSIONS: Different conceptual representations and the use of different key features might be a cause for inconsistent definitions of feedback. The characteristics, strengths and weaknesses of this research based operational definition are discussed.


OBJECTIVE: To evaluate how the utility (reliability, validity, acceptability, feasibility, cost and educational impact) of a communication-OSCE was influenced by whether or not station-specific (StSp) checklists were used together with a generic instrument and whether or not narrative feedback was provided to students.

METHODS: At ten stations, faculty members rated standardized patient-student interactions using the Common Ground (CG) instrument (at all stations) and StSp-checklists. Both raters
and patients provided written feedback. The impact of changing the design on the various utility parameters was assessed: reliability by means of a generalizability study, cost using the Reznick model and the other utility parameters by means of a survey.

**RESULTS:** Use of the generic instrument (CG) proved more reliable (G coefficient=0.67) than using the StSp-checklists (G=0.47) or both (G=0.65) while there was a high correlation between both scale scores (Pearsons'r=0.86). The cost was 6.5% higher when StSp-checklists were used and 5% higher when narrative feedback was provided.

**CONCLUSION:** The utility of a communication OSCE can be enhanced by omitting StSp-checklists and by providing narrative feedback to students.

**PRACTICE IMPLICATIONS:** The same generic assessment scale can be used in all stations of a communication OSCE. Providing feedback to students is promising but it increases the costs.


Feedback may be formal or informal. Formal feedback is planned as part of appraisal and assessment and occurs episodically. It may cover specific areas or outcomes as set down by the hospital or practice. Informal feedback should be given on a daily basis in relation to specific events (e.g., managing a case or doing a procedure). Indeed, daily feedback should be part of the culture of our hospitals and other sites of training.


An essential goal of evaluation is to foster learning. Across the medical education spectrum, evaluation of clinical performance is dominated by subjective feedback to learners based on observation by expert supervisors. Research in non-medical settings has suggested that participants’ perceptions of evaluation processes exert considerable influence over whether the feedback they receive actually facilitates learning, but similar research on perceptions of feedback in the medical setting has been limited. In this review, we examine the literature on recipient perceptions of feedback and how those perceptions influence the contribution that feedback makes to their learning. A focused exploration of relevant work on this subject in higher education and industrial psychology settings is followed by a detailed examination of available research on perceptions of evaluation processes in medical settings, encompassing both trainee and evaluator perspectives. We conclude that recipients’ and evaluators’ perceptions of an evaluation process profoundly affect the usefulness of the evaluation and the extent to which it achieves its goals. Attempts to improve evaluation processes cannot, therefore, be limited to assessment tool modification driven by reliability and validity concerns, but must also take account of the critical issue of feedback reception and the factors that influence it. Given the unique context of clinical performance evaluation in medicine, a research agenda is required that seeks to more fully understand the complexity of the processes of giving, receiving, interpreting, and using feedback as a basis for real progress toward meaningful evaluation.

**Purpose.** Instructional methods to help pharmacists succeed in their growing role in practice-based teaching are discussed, with an emphasis on techniques for fulfilling the four key preceptor roles.

**Summary.** The American Society of Health System Pharmacists (ASHP) and other organizations advocate ongoing efforts to develop the teaching skills of clinician educators serving as preceptors to pharmacy students and residents. The broad model of teaching clinical problem solving recommended by ASHP emphasizes the creative and flexible application of the four major preceptor roles: (1) direct instruction, (2) modeling, (3) coaching, and (4) facilitating. A variety of teaching methods used in the fields of medicine and nursing that can also be adopted by practice-based pharmacy educators are presented; in particular, the advantages and disadvantages of various Supplementary material is available with the full text of this article at www.ajhp.org. case-presentation formats (e.g., One-Minute Preceptor, SNAPPSS, patient-witnessed teaching, “Aunt Minnie,” “think-aloud”) are reviewed. Other topics discussed include the appropriate use of questioning as an educational tool, strategies for providing constructive feedback, teaching learners to self-evaluate their skills and progress, and integrating residents into teaching activities.

**Conclusion.** The ASHP-recommended approach to teaching clinical problem solving skills can be applied within the educational frameworks provided by schools of pharmacy as well as pharmacy residency programs. A wide range of validated teaching strategies can be used to tailor learning experiences to individual learner needs while meeting overall program goals and objectives.


Risky behaviors are a leading cause of preventable morbidity and mortality, yet behavioral counseling interventions to address them are underutilized in healthcare settings. Research on such interventions has grown steadily, but the systematic review of this research is complicated by wide variations in the organization, content, and delivery of behavioral interventions and the lack of a consistent language and framework to describe these differences. The Counseling and Behavioral Interventions Work Group of the United States Preventive Services Task Force (USPSTF) was convened to address adapting existing USPSTF methods to issues and challenges raised by behavioral counseling intervention topical reviews. The systematic review of behavioral counseling interventions seeks to establish whether such interventions addressing individual behaviors improve health outcomes. Few studies directly address this question, so evidence addressing whether changing individual behavior improves health outcomes and whether behavioral counseling interventions in clinical settings help people change those behaviors must be linked. To illustrate this process, we present two separate analytic frameworks derived from screening topic tools that we developed to guide USPSTF behavioral topic reviews. No simple empirically validated model captures the broad range of intervention components across risk behaviors, but the Five A’s construct-assess, advise, agree, assist, and arrange-adapted from tobacco cessation interventions in clinical care provides a workable framework to report behavioral counseling intervention review findings. We illustrate the use of this framework...
with general findings from recent behavioral counseling intervention studies. Readers are referred to the USPSTF (www.ahrq.gov/clinic/prevenix.htm or 1-800-358-9295) for systematic evidence reviews and USPSTF recommendations based on these reviews for specific behaviors.


**BACKGROUND:** Primary health care visits offer opportunities to identify and intervene with risky or harmful drinkers to reduce alcohol consumption. **PURPOSE:** To systematically review evidence for the efficacy of brief behavioral counseling interventions in primary care settings to reduce risky and harmful alcohol consumption.  

**DATA SOURCES:** Cochrane Database of Systematic Reviews, Database of Research Effectiveness (DARE), MEDLINE, Cochrane Controlled Clinical Trials, PsycINFO, HealthSTAR, CINAHL databases, bibliographies of reviews and included trials from 1994 through April 2002; update search through February 2003.  

**STUDY SELECTION:** An inclusive search strategy (alcohol* or drink*) identified English-language systematic reviews or trials of primary care interventions to reduce risky/harmful alcohol use. Twelve controlled trials with general adult patients met our quality and relevance inclusion criteria.  

**DATA EXTRACTION:** Investigators abstracted study design and setting, participant characteristics, screening and assessment procedures, intervention components, alcohol consumption and other outcomes, and quality-related study details.  

**DATA SYNTHESIS:** Six to 12 months after good-quality, brief, multicontact behavioral counseling interventions (those with up to 15 minutes of initial contact and at least 1 follow-up), participants reduced the average number of drinks per week by 13% to 34% more than controls did, and the proportion of participants drinking at moderate or safe levels was 10% to 19% greater compared with controls. One study reported maintenance of improved drinking patterns for 48 months.  

**CONCLUSIONS:** Behavioral counseling interventions for risky/harmful alcohol use among adult primary care patients could provide an effective component of a public health approach to reducing risky/harmful alcohol use. Future research should focus on implementation strategies to facilitate adoption of these practices into routine health care.


**OBJECTIVE:** We applied the self-determination theory of human motivation to examine whether patient perceptions of autonomy supportiveness (i.e., patient centeredness) from their diabetes care providers related to improved glucose control over a 12-month period.  

**RESEARCH DESIGN AND METHODS:** We conducted a prospective cohort study of patients with diabetes from a diabetes treatment center at a university-affiliated community hospital. Participants were 128 patients between 18 and 80 years of age who took medication for diabetes, had no other major medical illnesses, and were responsible for monitoring their glucose and taking their medications. The main outcome measure was a change in HbA1c values over the 12 months of the study.
RESULTS: Patient perception of autonomy support from a health care provider related to a change in HbA1c values at 12 months (P < 0.05). Further analyses showed that perceived autonomy support from the staff related to significant increases in patient autonomous motivation at 12 months (P < 0.05); that increases in autonomous motivation related to significant increases in perceived competence (P < 0.05); and that increases in a patient’s perceived competence related to significant reductions in their HbA1c values over 12 months (P < 0.001).

CONCLUSIONS: The findings support the prediction of the self-determination theory that patients with diabetes whose health care providers are autonomy supportive will become more motivated to regulate their glucose levels, feel more able to regulate their glucose, and show improvements in their HbA1c values.


This article describes a recent initiative, which used life-coaching to develop strong leadership skills and empower individual team members and the team as a whole. A three-stage process was used to enable a team of nurses in a GP practice to improve working relationships, leadership skills and stress management.


PURPOSE: The authors describe the development and validation of an institution-wide, cross-specialty assessment of residents’ communication and interpersonal skills, including related components of patient care and professionalism.

METHOD: Residency program faculty, the department of medical education, and the Clinical Performance Center at the University of Illinois at Chicago College of Medicine collaborated to develop six standardized patient-based clinical simulations. The standardized patients rated the residents’ performance. The assessment was piloted in 2003 for internal medicine and family medicine and was subsequently adapted for other specialties, including surgery, pediatrics, obstetrics-gynecology, and neurology. We present validity evidence based on the content, internal structure, relationship to other variables, feasibility, acceptability, and impact of the 2003 assessment.

RESULTS: Seventy-nine internal medicine and family medicine residents participated in the initial administration of the assessment. A factor analysis of the 18 communication scale items resulted in two factors interpretable as “communication” and “interpersonal skills.” Median internal consistency of the scale (coefficient alpha) was 0.91. Generalizability of the assessment ranged from 0.57 to 0.82 across specialties. Case-specific items provided information about group-level deficiencies. Cost of the assessment was about $250 per resident. Once the initial cases had been developed and piloted, they could be adapted for other specialties with minimal additional effort, at a cost saving of about $1,000 per program.

CONCLUSION: Centrally developed, institution-wide competency assessment uses resources efficiently to relieve individual programs of the need to “reinvent the wheel” and provides program directors and residents with useful information for individual and programmatic review.

In teaching, nursing management, and professional development, the traditional one-to-one approach is used in the peer coach relationship. In clinical environments, the use of peer coaches is a creative way to implement practice change. Tailoring the concept of peer coaching to consider the dynamics and structure of the clinical environment is essential. This article describes the use of a change model in the preparation of peer coaches for safe patient handling in an acute care setting. Unit-focused peer coach preparation includes multiple teaching techniques, such as lecture, hands-on experience, and scripting. Unit-focused peer coaches are a helpful adjunct to nursing staff development.


The authors discuss the challenging and difficult act of delivering feedback in a constructive manner. In addition, the authors address how receiving feedback offers rewards including providing an opportunity to gain useful information and insight into what we need to develop or improve in order to grow professionally.