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Improving Assertive Communication Skills in Simulated Medical Encounters

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Assertive communication is a powerful communication skill in everyday clinical practice among staff members and in doctor-patient encounters. It has an important role in eliciting relevant information during patient interviewing, similarly, in shared decision-making or convincing patients of certain therapy options. The skills are also needed in delegating tasks or giving feedback to colleagues. Through simulated medical encounters, culturally appropriate assertive communication skills can be improved to tackle challenges in hierarchical healthcare contexts. Our comparative study analyses the results of a questionnaire survey of two simulation-based communication courses, where one explicitly aims to use assertive skills in clinical settings while the other implicitly encourages students to defend their opinions in doctor-patient scenarios. Blended-learning methods, support from clinicians and mentors in promoting self-confidence and self-esteem, constructive feedback from both simulated patients and the observers (linguists, psychologists), teamwork skills training and assertive communication techniques were applied to ensure the effectiveness of the courses. The article shares the verbal and non-verbal tools of assertive communication evaluated by the observers, and the self-evaluations of students, which focused on their own behavioural changes in terms of sense of responsibility, sense of failure and navigating between assertiveness and empathy.

Keywords*: assertiveness, communication skills, simulated patients, medical encounters, constructive feedback*

Introduction

Assertiveness was already defined almost forty years ago as the legitimate and honest expression of an individual's personal rights, feelings, and interests without denying or violating the rights of others (Alberti–Emmons, 1974; Delamater, 1986). Thus, assertive communication is normally direct and clarifies a person's need with the other interactant. It is a specific skill that some people are born with, but it also can be learnt. People with advanced skills in assertiveness can reduce interpersonal conflict-related stress and anxiety.

Assertiveness, as an important interpersonal skill, also addresses power relations among interactants. Individuals who demonstrate assertive behaviours normally have higher self-esteem and are often much more successful (Mansour et al., 2020). One's assertive behaviour may be formed by various cultural and social factors. Even more, personality traits could be a possible influential factor in exhibiting assertive communication; being extrovert (friendly and happy) or introverted (anxious, shy and having low self-esteem) have all been associated with people's self-reported assertive behaviour. Assertiveness also has its culture-bound connotations, meaning, students who can study in a fair working culture improve their self-confidence during and after the training, and are less anxious about the potential negative outcomes that could arise from speaking out. During communication courses, it is important to reflect on cross-cultural perspectives and teach cultural norms, cultural values that define social behaviours, and the use of verbal and non-verbal codes. Williams argues that assertiveness training enhances self-confidence, self-esteem, interpersonal relationships, personal achievements, and sense of control (Williams, 1984). Assertiveness is the skill to ask for what one needs, name difficult feelings such as anger and disappointment, and negotiate effectively with others. With references to the above, we can say that assertiveness and the power of saying "No" may have a positive effect on mental health.

Life or psychosocial skills, including assertiveness, enable individuals to take social responsibility, make decisions, and manage conflicts without doing harm to themselves or others. In health care, medical students may eventually become doctors who will have daily interactions with colleagues, patients, and their families, so appropriate social skills are imperative tools for teamwork and patient safety (Hamoud et al., 2011, Omura et al., 2017). Assertiveness is a crucial social skill referring to the ability to say "No", make requests, express positive and negative feelings, and initiate, maintain, and end a conversation. As a benefit, it increases self-confidence, improves interpersonal communications, and enables individuals to act in accordance with their interests without irrational anxiety. Previous research demonstrated that staff with advanced communication skills face fewer problems, make fewer mistakes, use fewer resources, and manage difficulties more efficiently (Ayhan–Seki Öz, 2021). Contrary to this, communication failures, like inadequate information, have negative outcomes, including misdiagnosis, more frequent malpractice, patient dissatisfaction, and noncompliance with therapies.

Recent studies investigated associations between assertive behaviour and interpersonal communication, self-esteem, psychological well-being, stress, anxiety, and depression, job satisfaction, cultural sensitivity, and the power of ‘saying no’ (Pourjali–Zarnaghash, 2010, Cantero-Sanchez et al., 2021). They agree that developing assertiveness requires clear communication. If improved well, junior doctors may be able to question senior doctors about the patient’s health-related interest, which may be very awkward, but individuals with the above skills will feel more in control, confident, and empowered, which will ultimately benefit their patients, teams, and colleagues. Gie Ok Noh (2021) states that communicating with patients, caregivers, and health-care providers proves to be challenging for nursing students; so the increasing work-related stress they experience during clinical training needs to be managed by empowering them with assertive tools.

According to research on assertiveness training, role-playing, modelling, and providing feedback are effective practical approaches to acquire speaking up skills (Hewson and Little, 1998). When developing assertiveness, Wolpe aimed to relieve the individual of social fears and to maintain a high level of self-esteem, regardless of the failures in life. Apart from these new accents, Wolpe continued Salter’s practice of building the capacity for the free expression of feelings, behavioural spontaneity, and freedom in communication with people on different levels (Patterson–Watkins, 1996; Wolpe, 1990). Lazarus (1966) identified four groups of habits, like the ones mentioned above, that were possessed by assertive personalities and were conditions for a fulfilling life: the ability to openly talk about one’s own desires and needs, to say "No", to openly talk about positive and negative feelings, and the ability to establish contacts, to begin, maintain and end a conversation. The assumption of equality, which means respect for our own and others' feelings, needs, and rights, is a critical aspect of assertive behaviour, as is the assumption of constructive cooperation, which focuses on taking responsibility for pursuing our own needs while assisting others in asserting theirs. In assertive communication training, the most important steps to learn are listening to others, applying assertive rights, and expressing ourselves in ’me messages’ in a calm manner by using fact-based statements, open requests, verbalizing desires without anxiety, and saying “No” if needed. Our previous study (Eklics et al., 2022) revealed the importance of constructive feedback in improving students’ confidence and awareness; as we found, it also encourages the practice of assertive communication.

Method

Our comparative study analyses the results of a self-assessment of assertiveness questionnaire survey completed by participating students, and the observational results by instructors, ESP language and communication instructors and a psychologist, in two simulation-based medical

communication courses. To ensure the effectiveness of blended-learning methods, support from clinicians and mentors in promoting self-confidence and self-esteem, constructive feedback from simulated patients and the observers (linguists, psychologists), teamwork skills training, and assertive communication techniques were applied in both courses. The aim of the pilot study was to detect how different approaches can improve assertive skills.

The subjects of the study included twelve international and twelve Hungarian medical students attending courses like Taking Medical History with Actors: Simulation Practices in the MediSkillsLab, and Empathic and Assertive Communication in Clinical Practice. While the former provided an implicit approach, encouraging international students to stand up for themselves in doctor-patient scenarios and improving assertive communication skills through constructive feedback without clearly stating that we focused on it, the latter used an explicit approach, having presentations on empathy and assertiveness with sample scenarios and discussions.

The course with an implicit approach gave initial presentations on doctor-patient communication during history taking, highlighting verbal and non-verbal elements of patient-centred interviewing, and included weekly practices through simulated scenarios. During these scenarios, the students played the roles of doctors and/or medical students in teams, either while on practice in different hospital departments or during doctor-patient encounters with professional actors simulating patients. The task for the students was to take the medical history of the patient, lead the interview confidently with coherent turn-taking, break bad news, and inform the patient of therapeutic options. After the simulation practice, constructive feedback was provided by the actor-simulated patient, the clinician present, and the communication instructor, who reflected on behaviour, communication, and professional conduct.

The course with an explicit approach focused clearly on enhancing empathy and assertiveness in clinical settings. Week by week, theoretical background presentations were followed by simulated scenarios in which Hungarian students portrayed doctors and had one-on-one professional encounters with lay simulated patients, focusing on breaking bad news. After the role-play, the SP, peer students, a psychologist, and a communication instructor facilitated students' growth with constructive feedback on empathic and assertive communication.

Students from both courses were asked to take a self-assessment questionnaire survey during the final week of training. We applied the Rathus Assertiveness Schedule (Rathus, 1973), which contains 30 statements of different levels of assertive behaviour (passive, aggressive, passive-aggressive, and assertive). The students, using a scale (-3 to 3) assessed their assertiveness from -3=very much unlike me to 3=very much like me. The scoring categorized the participants into five different groups: -90- -20: very non-assertive/passive; -20-0: situationally non-assertive; 0-20: somewhat assertive; 20-40: assertive; and 40-90: aggressive.

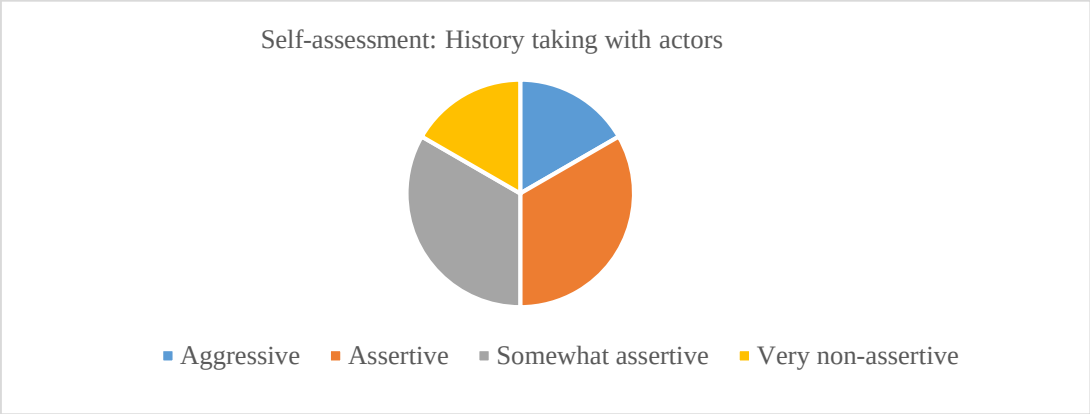
Our study also compared the observed behaviours of the students in the simulated scenarios in both courses. The instructors of the courses assessed the students on a scale of 1-5 for successfully completing the following tasks:

1) Initiating encounters: confidently greeting the patient, introduction, shaking hands, asking the patient to take a seat
2) Confident interviewing techniques: leading the conversations and actively listening to the patient, signposting thematic changes regarding history-taking elements
3) Managing patients' emotional responses: staying calm, focusing on the medical issues while expressing empathy, providing plans for future treatments, staying in the role, or having off-record comments
4) Closing the interactions: without feeling guilty or careless, finish the scenario and inform the patient that it is over, saying goodbye.

Results

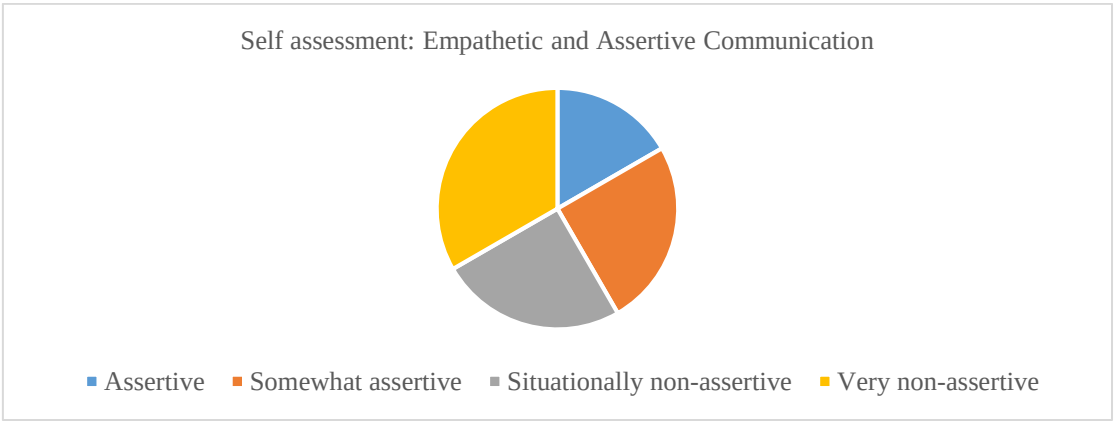
Results of the students' self-assessment based on the Rathus Assertiveness Schedule in the course that implicitly focused on improving assertiveness, Taking Medical History with Actors, showed that 66% of students consider themselves somewhat assertive and assertive. The extremes – very non-assertive or aggressive – represented only one third of the group.

Figure 1. Self-assessment of students based on the Rathus Assertiveness Scale in the course implicitly improving assertiveness.



In the course with the explicit approach, Empathetic and Assertive Communication in a Clinical Setting, the results of the students' survey revealed a shift towards non-assertive behaviour. Only 41% of the students assessed themselves as assertive or somewhat assertive, while 58% found themselves situationally non-assertive or very non-assertive.

Figure 2 Self-assessment of students based on the Rathus Assertiveness Scale in the course explicitly improving assertiveness.



Results of observations

In both courses, the assessment of students' success in *initiating encounters* was very similar, with the average score being 3. Despite the fact that there were only two (2) exceptionally outstanding achievements among international students in the course with an implicit approach, the average value did not change significantly. The observed *confident interviewing techniques* correlated with the students' self-assessment in the history-taking course with an average score

of 4 on the 1-5 scale, though *active listening* was significantly higher (5 compared to 3) in the empathetic course. About *managing patients' emotional responses,* more empathy was observed (9 students scoring 5) in the empathetic course, but more confidence (10 students scoring 4) was seen in *staying calm in the history taking* course. The area that participants from both courses struggled with was *closing the interactions,* where the average result was a score of 2. We believe that cultural differences, expectations, beliefs, and different norms may have been present in the background, and limited opportunity to practise these interactional moves may have influenced the results.

Discussion

Our pilot study compared the self-assessment of students and mentors' observation regarding assertive communication skills in two courses aiming to improve medical communication. We considered that using assertive communication tools with simulated patients contributed to the strengths of the courses, however, we were uncertain about the effectiveness of the differences in the applied approach, implicit vs. explicit. Based on the results, students' confidence, as an assertive skill, was more successfully and significantly improved with the help of regular constructive feedback in the implicit course than in the explicit one. Although, one must not exclude the role of international experience when comprehending this result. Active listening skills rated remarkably higher in the explicit, empathetic course among Hungarian students. Complete reasoning would also relate this result to Hungarian university students who listen in a more silent, receptive way than international ones. This demonstrates the positive outcome of the empathetic and assertive communication course, where more attention was given to listening skills as a major tool of empathy. Managing emotional responses was the strength of the students who completed the empathetic course. The survey and our observations confirmed that the main goal was to have empathetic assertiveness to tackle challenges in healthcare contexts.

One of the most important results from the study was the correlation between the mentors' observations and the students' self-assessment. This reinforced the need for further improvements in the shared understanding of the role of constructive feedback and the developed self-esteem and criticism of the students. Our pilot study had its limitations, such as the low number of participants as well as the cultural and norm differences among the students. In the future, we intend to revise and update our study by introducing identifications for each student (signs), testing in the first and last weeks of the programme to compare growth within the courses, and involving more observers for objective analysis throughout the training.

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