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Evaluation of a simulation-based Risk Management and Communication Masterclass to reduce the risk of complaints, medicolegal and dentolegal claims

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ABSTRACT

Objectives To understand clinicians' experiences, learning and professional impacts following participation in a Risk Management and Communication Masterclass (RMCM) designed and delivered by Medical Protection Society. To identify the course's strengths and areas for enhancement.

Design Mixed method study including semistructured telephone interviews. Interviews were conducted between October and December 2017, 6–30 months after course participation. Data were subjected to a thematic analysis. Quantitative analysis of participants' feedback ratings (n=486) on RMCMs delivered between December 2014 and May 2017 was also undertaken.

Setting RMCMs were delivered to Doctors and Dentists based in the UK and Ireland and South Africa. Participants: A sample of 12 volunteer doctors (Obstetricians/Gynaecologists, Orthopaedic/Spinal Surgeons, General Surgeons, Paediatricians, General Practitioners) and dentists chosen to represent different clinical specialities accepted the invitation to participate.

Results Study participants reported examples of person-centred communication skills such as empathy, shared-decision making and managing patient expectations in their workplaces following participation in the RMCM. Many clinicians gave examples describing how they used the communication models they learned when back at work. They also demonstrated a better understanding of the motivations for patients to complain or claim. RMCM course participants' high feedback ratings provided further evidence that the course was valuable and met learning objectives.

Conclusions It may prove difficult to demonstrate quantitatively that liability improves as a direct result of risk management and communications training. Our results on other dimensions (reactions, learning, behaviour change and impact) suggest that the RMCM has a positive and durable effect based on participant feedback.

BACKGROUND

Multiple factors impact on a doctors' risk of experiencing a complaint or medicolegal claim. A frequent reason that predisposes patients to complain or take legal action, should they suffer a poor care experience, is suboptimal communication with their doctors.[1–3] Litigious intent and quality of the doctor-patient communication appear to be related[4 5] and indeed many complaints and claims arise in the absence of clinical error.[6 7]

Many patients are not involved as much as they would like to be about decisions that involve them.[8] Where patients are, for example, undergoing surgery, most want to be offered choices and asked their opinion when making decisions involving surgery.[9 10] Furthermore, patients who have experienced suboptimal care are less likely to complain if their healthcare professional has communicated clearly and provided them with enough information, a satisfactory explanation[11] and a timely, sincere, culturally appropriate and meaningful apology.[12]

Studies of claims against medical practitioners have shown that the perceived cause, context, outcome and response to a given case influence the probability that a claim is pursued and the type and amount of remuneration awarded.[13 14] In terms of the consequences for practitioners, Bourne *et al*[15] found that UK doctors with current or recent complaints reported higher levels of anxiety, stress and depression than those with no complaints, with distress increasing when a complaint is escalated, for example, to the professional regulator.[15]

From our Medical Protection Society (MPS, box 1) experiences, ineffective doctor-patient communication is frequently cited as a factor leading to medicolegal cases, while suboptimal dentist-patient communication is a significant factor for dentolegal cases. Indemnity costs are increasing worldwide; therefore, any reduction in the frequency of liability cases will benefit patients, clinicians, healthcare organisations and indemnity providers.

Unhelpful communication habits can be formed over time and contribute to a less than ideal outcome for doctors, dentists and patients. The training of specialists has traditionally focused on the essential biomedical and technical aspects of clinical care. However, many specialists recognise the need for proficiency in a range of non-technical skills, such as communication and organisational skills, for them to be fully effective in their therapeutic role. Systematic reviews have identified the most effective communication skills training for clinicians being role-play, feedback and small group discussions,[16] while use of simulated patients is reported to be a valuable and effective means of providing communication skills training.[17]

In this evaluation of a 1-day Risk Management and Communication Masterclass (RMCM), we aimed to better understand doctors' and dentists' reported motivations, experiences, learning and professional impacts following participation in this training intervention. Key objectives were:

Box 1 About the Medical Protection Society (MPS)

The MPS is a leading mutual, not-for-profit membership organisation. It protects and supports the professional interests of more than 300 000 members worldwide. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice. In the UK, MPS manages claims for clinical negligence brought against members who are General Practitioners (GPs), private doctors and dentists while the NHS Litigation Authority manages claims arising in the NHS hospital sector.

MPS provides expert assistance for its members with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries. The RMCM has been developed to provide experienced clinicians an interactive and practical day of professional development. The purpose is to help them reduce their medicolegal and dentolegal risk and enhance patients' experience through effective communication.

1. To solicit feedback from participants on the perceived strengths of the RMCM and course elements that could be enhanced.
2. To explore and describe self-reported performance improvements (eg, reported impacts or modified behaviours) associated with RMCM participation.

METHODS

MPS has been delivering a 1 day RMCM since 2013 in the UK, Ireland and South Africa. The RMCM was developed to provide experienced medical doctors and dentists with an interactive and practical day of professional development and to help them address the challenges of complaints and litigation associated with working in higher risk specialities (box 2). MPS is aware of the potential impact that claims and regulatory proceedings can have on professional careers and provides education and risk management training on the basis that '*prevention is better than cure*'. For participants, the key development objectives are to:

- Understand the motivations for patients to complain or make a claim.
- Examine and rehearse different communication techniques to enhance person-centred care and reduce medicolegal risk.
- Develop and enhance specific skills around making a personal connection, empathy, active listening, expectation management, shared decision-making, checking understanding and handling disappointment.

The RMCM uses a combination of work with simulated patients, feedback and small group discussions as the basis of the communication skills training delivered, which are reported as the most effective educational strategies.[16 17] Simulation is a technique to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner. The RMCM has been designed so that the included scenarios and simulated patients feel realistic for the participants, while there are ample opportunities for discussion and interactions to stimulate participants to reflect on their experience and make behavioural changes on return to work, which fits with the principles of adult learning theory.[18]

Box 2 Description of Risk Management and Communication Masterclasses

Background
Medical Protection Society (MPS) recognised that some specialities were experiencing more medicolegal cases than others and wished to provide an education intervention. In 2013, we designed and developed an innovative Risk Management and Communication Masterclass (RMCM) to provide experienced clinicians a tailored, interactive and practical day of professional development. The main purpose is to help clinicians manage the challenges of litigation associated with working in higher risk specialities. This will help to achieve the additional goals of improved patient safety and care quality.

Objectives
The key development objectives for the participants are to develop skills relating to making a personal connection, active listening and to recognise how to communicate empathy. In addition to enhance skills in shared-decision making, checking understanding, managing expectations and understanding the motivations for patients' desire to complain or claim.

Format
The set content of the sessions has been derived from international research and MPS insights from its library of case studies. The day focuses on practice orientated communication skills before an adverse outcome, such as consent and shared-decision making and then how to effectively handle a disappointed patient after they have experienced an adverse outcome. In the morning, the faculty present evidence behind interventions to reduce risk and facilitate small group discussions. Patient videos are used to introduce the ASSIST© communication model. The model has been developed by MPS to aid discussions following an adverse outcome (Acknowledge, Sorry, Story, Inquire, Solution, Travel). The facilitators lead an exercise for participants to recognise and reflect on their own emotional triggers (hot buttons) so as to work effectively with a disappointed patient. After lunch, the participants are split into two groups in separate rooms and all take part in speciality-specific role play scenarios with professional actors. The participants receive immediate feedback from the actors and faculty and are encouraged to reflect on their experiences. There is a set format for the day in order to reduce the variability of training delivered across the range of settings.

Setting
Speciality-specific RMCM were first developed for Obstetricians/Gynaecologists, Orthopaedic/Spinal Surgeons and General Surgeons and run in Dublin, Ireland. In the second year of the development, these programmes were run in Johannesburg and Cape Town, South Africa and cites in the UK. We then developed a RMCM for general practitioners and ran this in Dublin and cities in the UK. In 2016, a RMCM was designed for dentists and run in cities in the UK and in Dublin. A sixth speciality specific RMCM was designed for Paediatricians and run in Johannesburg and Cape Town, South Africa. The RMCMs take place in selected hotels with suitable safe environments for providing a role play format and opportunities for formal and informal discussions.

Participants
The number of participants per RMCM is between 14 and 18. MPS selects some members who have experienced more liability cases than their peers to be invited to participate in RMCMs and also uses targeted marketing to other members by the location

Continued

Box 2 Continued

of the RMCM. At each RMCM, there is usually a mixture of senior and junior clinicians who have a range of different medicolegal experiences. During the day, there are frequent opportunities for participants to interact with each other.

Faculty

The RMCM faculty are all experienced enthusiastic medical and dental educators who have been selected to deliver the RMCM. Each RMCM is facilitated by two clinicians who are based in the UK, Ireland or South Africa. The faculty undergo training to deliver the RMCM content, work with and direct role-play actors and provide non-judgemental debriefing. All the faculty members are required to pass an accreditation assessment by MPS senior educators before delivering the RMCM. The faculty provide psychological support for any participants that require this following the role play scenarios. The MPS senior educational team provides support for the faculty and continuing professional development faculty-training days every 12–18 months.

Simulated patients

MPS has contracted a small number of professional actors from one UK and one South African company, which supply actors for communication skills training. The actors are trained by the MPS senior educators to provide immediate feedback to the participants during the role play specialty-specific scenarios. They are matched according to age and gender for each scenario to make it as realistic as possible. Two professional actors are used for each RMCM.

Evaluation and updates

The overall management, leadership and development of the RMCM programme are led by the MPS senior education team. All participants are asked to complete a standard feedback form at the end of the day. Data analysis of the feedback ratings is provided by an independent company to MPS. The RMCMs are reviewed yearly and the content is updated to incorporate any new medicolegal and dentolegal developments. The performance of the professional actors is continuously monitored to ensure it is valid and reliable.

Continuous professional development

The RMCM is accredited for clinicians to receive 6 CPD points.

Costs

MPS provides RMCMs as a benefit of membership to reduce medicolegal risks and enhance patient experience and safety. MPS delivers 15–25 per year.

Relationship between RMCM participation and the desired outcomes

We want every RMCM participant to subsequently manage effectively all the challenges of litigation they experience. Being able to communicate empathy and understanding patients' desire to complain or claim should reduce the frequency of patients being dissatisfied with their clinician. However, we understand that the reasons behind litigation are often multiple and complex and therefore some specialists will experience litigation cases after participation.

Participant selection and recruitment

Thirty-nine RMCMs were delivered in UK, Ireland or South Africa between December 2014 and June 2017. All 504 past participants were invited to be interviewed in October 2017 whether they had been selected to take part in a RMCM by MPS or had voluntarily decided to participate. The authors were blinded to participants' case experience and any previous contacts with MPS. Potential participants were sent information about the evaluation aims and asked if they would voluntarily agree to participate in a telephone interview for 30–45 min at a pre-agreed time. Six volunteer participants were initially selected to be interviewed who were reflective of different countries and specialties to provide diversity of opinion. This process was then repeated with a further group of six volunteer participants. All participants received a certificate of participation demonstrating evidence of reflection on the impact of learning, which could be submitted as a continuing professional development (CPD) learning credit.

Data collection

Data were collected via semistructured telephone interviews[19] conducted during October–December 2017 by an independent qualitative researcher (LH). Interviews were audio-recorded and digitally transcribed with consent and contemporaneous field notes were also taken. The median time taken for interviews was 29 min (range: 19–38 min). A completed COREC checklist for reporting qualitative studies is provided (online supplementary file 1) and a logic model for guiding this evaluation is available (online supplementary file 2). LH undertook two pilot telephone interviews with senior MPS educators to test the initial topic guide (online supplementary file 3) which was agreed, then reviewed and further modified (online supplementary file 4) by all authors following analysis of the first six interview transcripts. Interviews were guided by (but not constrained by) the flexible interview topic guide to enable a fuller range of participants' views and experiences to be captured.

Data analysis

Thematic analysis[20] of the first six interview transcripts was conducted independently by the first four authors. All carefully read and re-read the transcripts and then coded and categorised data on an iterative basis. The authors spent 1 day together in November 2017 to compare data analyses and generate initial themes by merging, adding to or deleting their pre-existing categories and themes.

The group then reviewed the interview topic guide which was further modified so that there was scope for LH to explore the initial themes in these interviews. The modified guide was updated to better understand the interviewees' perception of the impact of the RMCM and also their relationship with MPS. The second set of transcripts were carefully read and re-read independently by each group member, who then spent a second day together in January 2018 to recompare data analyses and finalise the themes. Disagreements were resolved by discussion and debate, until consensus was reached.

RMCM participant demographic data was collected from the MPS membership database and anonymised. Postcourse evaluation data from all previous RMCM participants comprising responses on a 7-point Likert scale to 14 attitudinal statements was also summarised and is presented as a mean rating for each statement, with SD and range (table 1).

RESULTS

Most participants undertook the RMCM 6–18 months prior to interviews. Two participants had been selected by MPS following a review of their case experience and advised to participate. Demographic details of all RMCM participants and study interviewees are outlined in table 2.

Four main themes were identified:

Table 1 Participants' feedback ratings (n=486) of RMCMs delivered between December 2014 and May 2017

Statement	Mean feedback score (range, SD)
The presenter was able to effectively convey the concepts and ideas	6.72 (1–7, 0.62)
The event's learning objectives were met	6.66 (1–7, 0.69)
The overall organisation of the event was of a high standard	6.74 (1–7, 0.59)
The presenter's explanation and handling of exercises and activities were effective	6.72 (1–7, 0.62)
The overall quality of workbooks/course materials was of a high standard	6.59 (1–7, 0.69)
I am likely to change something in the way I practise as a result of this workshop	6.62 (1–7, 0.73)
I would consider undertaking future Medical Protection educational events	6.68 (1–7, 0.67)
The presenter showed a high level of skill in managing the group	6.78 (1–7, 0.56)
The event's content was interesting	6.62 (1–7, 0.68)
The event's content was relevant to me	6.68 (1–7, 0.67)
I would recommend this Medical Protection educational event to my colleagues	6.72 (1–7, 0.67)
The booking process was easy	6.51 (1–7, 0.95)
The presenter was courteous and respectful	6.85 (1–7, 0.56)
The event was worthwhile attending and met my learning needs	6.75 (1–7, 0.69)

Participant ratings on the following 7-point Likert scale: Strongly agree 7, Agree 6, Slightly agree 5, Neutral 4, Slightly disagree 3, Disagree 2, Strongly disagree 1.
RMCM, Risk Management and Communication Masterclass.

Table 2 Demographic details of RMCM participants and interviewees

	Interviewees n=12		Participants not interviewed n=492	
		Median age (range) years		Median age (range) years
Age		41.4 (27–69)		49.1 (27–85)
Female	58.3%		37.2%	
Male	41.7%		62.7%	
Location of RMCM				
South Africa	2	63.5	117	54.3
Ireland	3	35.6	52	46.4
UK	7	43.4	323	47.8
Specialty				
Surgery	0		71	51.2
Paediatrics	0		16	50.2
Orthopaedics and Spinal surgery	2	63.5	61	53.6
Obstetrics and Gynaecology	2	36.5	46	48.9
General Practice	2	40.0	206	49.7
Dentistry	6	36.2	92	43.5
Year participated in RMCM				
2017	3		107	
2016	7		242	
2015	2		114	
2014	0		29	
School of primary qualification				
South Africa	1		100	
UK	8		178	
Ireland	2		32	
Asia	1		70	
Africa (outside of South)	0		18	
Other European countries			35	
Not known			58	
RMCM suggested by MPS	2 (16%)		13 (2.6%)	
Medicolegal cases reported 2007–2017 mean (SD)	4.0 (4.95)		3.4 (3.95)	

MPS, Medical Protection Society; RMCM, Risk Management and Communication Masterclass.

- Peer interaction.
- Emotional journey and developing new insights.
- Experience of the RMCM.
- Improvements suggested.

Peer interaction

Peer-to-peer interaction helped put delegates at ease, normalised the issues and supported mutual learning. Delegates gained support from each other by bonding with new faces over coffee breaks and lunch. Most spoke about spending large periods of time working in isolation from their clinical colleagues, and so felt comforted to feel part of a group and of 'not being alone', while others reported providing and receiving moral support on the day.

> 'I've established a relationship with three of the guys who were there; it's much more focused, because we've all experienced those situations' [Interviewee 5, South Africa based Orthopaedic Consultant]

Many had experienced the stresses of being involved in claims and complaints. Following peer interactions, there was a realisation that these issues are more common than realised. The RMCM provided a safe environment where delegates could share their stories and experiences unjudged, while fostering a sense of being 'in it together'.

> 'Sometimes dentistry can feel really isolated, you can feel like you're out on your own sometimes, it was quite interesting on one of these days to hear people talking about experience of receiving a complaint/referral to GDC {General Dental Council}' [Interviewee 8, UK based Dentist]

Participants reported learning from each other's questions, comments, suggestions and by watching role play activity. Those with less professional experience felt emboldened by learning with senior staff, while those with more experience also learnt from colleagues with more recent undergraduate training and a fresh perspective on patient handling and communication skills.

> 'The role play at the end of the day was really useful and beneficial, to see how other people reacted in certain situations, and then we debriefed and broke that down, you know how they could have done this' [Interviewee 8, UK based Dentist].

Emotional journey and developing new insights

Delegates asked by MPS to attend the RMCM felt strongly that it had been a valuable experience, despite initial reservations and concerns.

> 'I had a problem with a claim, and that was a communication thing that it boiled down'[Interviewee 3, UK based Dentist]

The course provided much more insight and value than expected and these participants reported enhanced behavioural insights about themselves and about patients. The newly acquired communication tools and practical skills helped increase their confidence back at work, enhance understanding of the risk of

experiencing complaints and claims, leading to a feeling that their individual practice was 'normal'.

> 'I really started to enjoy it more and more and I realised that there are shortfalls in my training especially with communication' [Interviewee 1, South Africa based Orthopaedic Consultant]

Learning new skills, practical frameworks, personal behavioural insights and a new empathy for patients were all reported. A notable shift in perceptions was apparent which included descriptions of more thorough, patient-focused and calm consultations, active listening, reduced unnecessary treatments, greater patient satisfaction, improved feedback from colleagues and patients and more measured response to confrontations.

> 'I think I've identified the areas where I was going particularly wrong, or I was cutting in too early' [Interviewee 7, Ireland based Dentist]
> 'Consultation is more thorough, that the patient has had more time to express their views and ask their questions and share bad news with patients' [Interview 1, South Africa based Orthopaedic Consultant]
> 'I'm not rushing to hammer through 30 patients in a session' [Interviewee 3, UK based Dentist]
> 'If there's any disgruntlement or something that the patient's not happy with, I spend the time with them just to find out exactly what they're not happy with' [Interviewee 6, UK based Dentist]
> 'I have had a lot more people, kind of, specifically referring someone to me, instead of the practice—patients being happier with me' [Interviewee 7, Ireland based Dentist]

A change in perspective was reported by most in terms of being better equipped to prevent complaints. Delegates gave accounts of being able to identify warning signs early, 'nip complaints in the bud' and of being more likely to be proactive in managing patient expectations by realising that failure to do this could lead to a complaint. Overall, delegates felt more confident in involving patients in decision-making.

> 'I think the main thing I took away from there was very much just, when the patient's really annoyed, the main thing I took away is to just sit there and let them get it all out, and immediately they'll start to calm down and come back to your level, and then you can have a proper dialogue with them.' [Interviewee 8, UK based Dentist]

Other positives described included enhanced work satisfaction, less stress and managing difficult consultations by not reacting and getting flustered, which had a positive emotional impact on the clinicians.

> 'I definitely enjoy more after having learnt this art of consulting, treatment with that patient was actually very rewarding' [Interviewee 1, South Africa based Orthopaedic Consultant]
> 'That makes me feel more comfortable when somebody comes in and is unhappy' [Interviewee 7, Ireland based Dentist]

Experience of the RMCM

The speciality-specific scenarios with simulated patients were strongly reported as the most valuable part of the day and were perceived as a very realistic, but safe experience. The pressure of performing in front of peers elevated the emotion of the simulated patient experience.

> 'What dental training is missing a lot, which is, especially when it comes to managing complaints and managing risks, actually getting the opportunity to try it with somebody who could really push you to the limit' [Interviewee 8, UK based Dentist]

Participants received immediate feedback from the actors and reported new insights on seeing consultations from a patient perspective (via the actors). The facilitators encouraged the delegates to use new models of communication which had been introduced at the start of the RMCM. At the end of the day the delegates were encouraged to reflect on their experiences. This provided reassurance and also some recognition of own behaviours and gaps. Delegates were asked to consider ways in way they could put into practice new behaviours when they return to their own work places.

> 'I think, for me, I felt like I did very well in the role play, which was encouraging for me.' [Interviewee 7, Ireland based Dentist]
> 'In retrospect it was the best thing that could have happened. I learnt a lot. I'm just sad that I didn't learn it earlier in my career' [Interviewee 1, South Africa based Orthopaedic Consultant]

Perceived barriers to change

Barriers to changes in practice and behaviours were reported such as time pressure, lack of opportunity to practice and poor recall. The perception was that dissatisfied patients are rare, so the opportunity to practice the ASSIST© model and manage their 'hot buttons' (emotions triggered by some patient comments) can easily be forgotten by the time a relevant situation arises. Equally, the discipline required to affect behaviour change in practice can be disrupted by new shift patterns or other changes, making it harder to embed new behaviour. Recall and use of some of the steps of the ASSIST© model was reported. Those who reported use of all six steps of the model made regular use of hand-outs or had notes on standby in case of an incident.

> 'I haven't had an incident where I would be needing it' [Interviewee 4, Ireland based Dentist].
> 'Sometimes I forget some of the steps, but the main flow of it I try to apply, generally, every day' [Interviewee 6, UK based Dentist]

Improvements to the RMCM

Ensuring course materials, such as videos and references, are as up-to-date as possible and suggesting ways to enhance the process of embedding the learning were put forward as recommendations. To provide more suggestions to overcome the perceived barrier of a lack of time in consultations and advice on opportunities to practice new skills.

DISCUSSION

Summary of main findings

In this small study, examples of communicating empathy, using practical models learned, and managing patient expectations in their workplaces following participation in the RMCM were described by many participants. They also demonstrated making a personal connection, active listening, shared decision-making, checking understanding and handling disappointment. The reported barriers to change along with the feedback from the facilitators have enabled us to make recommendations to enhance the impact of the RMCM.

This study reports the impact of providing risk management and communication training using simulated patients to enhance skills relating to making a personal connection, empathy, active listening, expectation management, shared decision-making, checking understanding and handling disappointment. The use of simulated patient scenarios was perceived as being a valuable experience, and participants were satisfied with being able to share stories and support received from peers, which is supported by high feedback ratings for the RMCM evaluations over time. Participation also led to reported learning of new communication tools, learning from peer participants and high feedback ratings on meeting the event learning objectives and the

benefits of formal and informal peer social interactions. In terms of self-reported evidence of changes in behaviour and transfer to the workplace this would include more thorough patient-focused consultations and enhanced behaviour insights, while there were also reports of better work satisfaction, less stress and managing difficult consultations by not reacting and getting flustered which had a positive emotional impact on the doctors or dentists. The analysis has also enhanced our understanding of the emotional journeys experienced by RMCM participants. This includes their relationship and views of MPS before, during and after participation.

Educational events are multifaceted interactions occurring in a changing world and involving the most complex of subjects. Many factors can influence the effectiveness of educational interventions. A systematic review reported that CPD activities that are more interactive, use more methods, involve multiple exposures, are longer and are focused on outcomes that are considered important by physicians lead to greater improvement in physician performance.[21] CPD is valued and is seen as effective when it addresses the needs of individual clinicians, the populations they serve and the organisations within which they work. However, the challenge for CPD may lie in the dynamic interaction between educational opportunities and service delivery requirements, as there may be occasions where they vie with each other for resources.[22] Following participation in CPD programmes, we acknowledge that behaviour is also modified by a range of other 'levers' including environment experiences, organisational culture, social interaction and support.

Systematic reviews of the literature of the effectiveness of communication skills training for clinicians identified the best educational strategies as role-play using simulated patients, feedback and small group discussions.[16 17] The target populations in the review included medical students, nursing students, nurse practitioners, oncologists, physicians (experienced and trainees) and other healthcare practitioners. The population in our study were mainly experienced clinicians from surgical-based specialities, general practitioners and dentists.

We have provided a description of the RMCM (box 2) and indicated how the programme meets the ASPiH (Association for Simulated Practice in Healthcare) standards for simulation-based education.[23] We feel that we met our first objective to solicit feedback from participants of the perceived strengths of the RMCM and elements that could be enhanced. The reported barriers to change along with the feedback from the facilitators have enabled us to be confident in making key recommendations to enhance the impact of the RMCM.

Our aim was to recruit a sample of interviewees who reflected the population of clinicians who participated in the RMCM. The RMCM is run in three different countries and for six different specialty groups. We recruited from all three countries and from a range of specialities (Orthopaedics, Obstetrics and Gynaecology, Dentistry and General Practice). The key themes we identified were consistently found across the interviewees. We felt we had saturated the themes from the observations made from the 12 interviews. We were not able to recruit any General Surgeons or Paediatricians, so our findings may have less external validity for these groups.

It is possible that the reported impacts by the interviewees were not solely as a result of their participation in the RMCM. The likelihood of successful behaviour change in the workplace following participation in a CPD event does depend on their commitment to change.[24]

Some of the interviewees reported having participated in other MPS-run communication workshops. We know the communication models used in some of these workshops are the same as those used in the RMCM. We feel that the reported impacts are likely to follow participation in a RMCM which may be supported by participation in other MPS workshops. The detail of the specific examples of impact relating to the RMCM reported, 6–30 months after, suggested that the study did capture behavioural changes specifically related to the RMCM.

Study strengths and limitations

An external, independent qualitative researcher undertook the interviews to reduce social desirability bias. All authors are experienced educational researchers with a range of clinical, safety and improvement expertise. By conducting interviews 6–30 months after participation, we aimed to capture the self-reported impact of the RMCM, behaviour changes and barriers to change, although recall bias may have been an issue. The use of semistructured telephone interviews is a pragmatic research method and convenient means of exploring issues in-depth, particularly when attempting to access time-pressured clinicians in multiple settings.[19] We also sampled to reflect the different professional groups, although study participants were younger, more likely to be female and work in dentistry in the UK than those who did not participate. We acknowledge that the findings are limited to the views and perceptions of those interviewed; however, we agreed that the themes identified reached saturation so feel confident that we captured the key reported observations.

Some participants were selected to take part in the RMCM by MPS; it is possible that may have influenced the reported changes to practice. We are aware that the interviewees were all members of MPS. Some will have already received expert advice and support for complaints or claims from MPS arising from their professional practice. As such they will have developed a view with regard to their ongoing relationship and membership with MPS. An independent researcher was employed to act as an 'honest broker' and assure participants that their answers were completely anonymised and to try and overcome any issues around participants feeling restricted in their responses due to their relationship with MPS. The factors leading to medicolegal cases are frequently secondary to a complex relationship between safety culture, patient expectations, candour and the effectiveness of organisational approaches to addressing liability and provide support programmes for clinicians.[25] The RMCM enhances individual skills in managing expectation and candour; however, we acknowledge that organisational factors are usually outside of the control of the individual. Finally, we fully acknowledge that the self-reported changes and new insights cannot be fully verified and are cautious about the strength of this type of evidence.

The study was insightful in terms of reviewing and improving the content and delivery of the RMCM and understanding how participants develop new insights and change practice to improve their consultation skills. The findings may have some wider implications for other providers of risk management and communication skills training programmes, educational researchers and policy makers. We acknowledge the participants of the RMCM were mainly experienced surgical specialists, GPs and dentists, so the findings may not apply to all medical and dental practitioners. We plan to use pre-post retrospective surveys in future research as we feel this could enhance our measurement of learning. A further area for future research would be around following up participants of RMCM to access how long any reported positive outcomes persisted and the frequency of experiencing complaints and claims. A recent systematic review found some evidence that simulation-based education can lead

to improvements in communication that can be translated into the clinical workplace. Based on the evidence reviewed, the authors also suggested a model for this type of communication skill simulation education, and this will prove to be useful in reviewing and enhancing the content of the RMCM.[26]

CONCLUSION

The combined findings from qualitative semistructured telephone interviews and RMCM participants' feedback ratings have provided evidence of performance improvements. The RMCM format which includes use of simulated patients, feedback and small group discussions is a valuable and effective means of enhancing patient-focused communication skills for experienced medical doctors and dentists. While it may prove difficult to demonstrate quantitatively that medical liability improves as a direct result of communications training, our results on other dimensions (reactions, learning, behaviour change and impact) suggest that the RMCM has positive and durable effects based on participant feedback.

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Competing interests JJ, LD and MD are employees of the Medical Protection Society, a protection organisation for healthcare professionals.

Ethics approval Under UK 'Governance Arrangements for Research Ethics Committees', ethical research committee review is not required for service evaluation or research which, for example, seeks to elicit the views, experiences and knowledge of healthcare professionals on a given subject area. Similarly, 'service evaluation' that involves NHS staff recruited as research participants by virtue of their professional roles also does not require ethical review from an established NHS research ethics committee.

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