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Using patients as educators for communication skills: Exploring dental students' and patients' views

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Abstract

Title: A qualitative study to explore the issues for patients and students when giving feedback on the communication of dental students.

Objectives: The Department of Health and National Institute for Health Research are committed to involving patients in improving clinical education, research and service delivery. Yet, there is a limited body of evidence on the perceptions of patients when asked to be involved in this way, and specifically when asked to provide feedback on the communication skills of dental students. This study seeks to address this gap and heighten the understanding of the issues faced by patients when asked to be involved in clinical education.

Methods: Data were collected using focus groups with dental students (n=10) and patients (n=8) being treated by these students. Both groups were asked about their thoughts, feelings and beliefs about patients being asked to provide feedback on the communication skills of dental students. Data analysis involved inductive thematic analysis of transcribed audio recordings.

Results: Four themes emerged from the data: "legitimacy," "co-educators," "maintaining the equilibrium of the patient-student relationship" and the "timing of patient feedback." Support for involving patients in giving feedback on students' communication skills was established, with patients considering they were best placed to comment on the communication skills of dental students. Patients and students do not want to provide feedback alone and want support to assist them, especially if feedback was negative. Issues of anonymity, confidentiality and ownership of the feedback process were worrisome, and the positioning of patient feedback in the programme was seen as critical.

Conclusions: Patients and students are willing to engage in patient feedback on students' communication skills, and with support and training, the concerns around this are not insurmountable and the benefits could potentially profit both groups. These findings have resonance with other healthcare educators when using patients as educators in the development of communication skills.

KEYWORDS

clinical education, communication skills, dentistry, patients

1 | INTRODUCTION

Engaging with patients in an active way to improve medical education, research and service delivery is recommended in the UK at national level by the Department of Health (DH)¹ and the National Institute for Health Research (NIHR)² underlined by the Francis and Berwick reports.³⁻⁵ Their aim is quality care focused on the needs of the patient stating the “*patient voice should be heard at all times*.”⁵ This paper focuses on the role of patients in medical education, specifically dental education and using patient feedback to develop students’ communication skills.

The Health Foundation considered “Can patients be teachers?” encompassing a literature review, telephone interviews and web-based surveys of UK medical and dental schools.⁶ They noted a great diversity in the involvement of people who are patients in medical education, notably for social care and mental health professions, but with little data from dentistry. A strong evidence for short-term benefits for all stakeholders but little long-term evaluation of outcomes was recognised. Further good-quality research was recommended to develop the evidence base of sustainability and behaviour change.

The wider literature on patient involvement in medical education may have relevance to dental education.⁷⁻¹⁰ Patients see themselves making significant contributions to the training of medical students as they consider themselves experts in their conditions.¹¹ Lauckner, Doucet and Wells discuss the challenges and benefits faced by patients with long-term health conditions sharing experiences with students.¹² Patient participants spoke of “*personal learning about their condition*” and “*making valued contributions*” as the main benefits. “*Potential vulnerability*” around sensitive emotional topics was the main challenge. Overall, the benefits outweighed the challenges and it was concluded that both could exist simultaneously when factors such as disclosure monitoring or receptivity of learners are managed.

There is strong support from educators and students for patient educators in medical education.¹³ Oswald et al. noted the students found communicating with real patients advantageous as the patient educators were seen as unique individuals rather than standardised cases and together were valuable partners in their treatment.¹⁴ Patient educators are seen to facilitate a learning environment that adds authenticity and makes space to ask “*stupid*” questions and learn from mistakes.¹⁵ A balanced power relationship between patient educators and students is desirable to support the legitimacy of learning. Making space for asking questions and being permitted to make mistakes facilitates this.¹⁵

Skilful communication is arguably a fundamental enabler to patient care. Multiple teaching and assessment methods examining student communication with their patients have been reported.¹⁶ Whilst there is a plethora of research and guidance from medical, nursing and allied healthcare professions regarding appropriate communication skill training, there is little evidence relating directly to dental education. Amongst the benefits specifically noted when dentists demonstrate effective communication skills are increased patient satisfaction,¹⁷⁻²⁰ improved patient adherence to dental recommendations,^{21,22} decreased patient anxiety²³⁻²⁵ and lower rates of litigation.²⁶⁻²⁸

Advanced communication skills are needed to grasp the unique perspective each patient brings to each clinical encounter. As reflective practitioners, healthcare professionals have a duty to examine whether two-way understanding is happening when they communicate with their patients. One of the ways to evaluate whether understandable interactions have occurred is to receive feedback from the recipient of the dialogue. Feedback has been described as the “*heart of medical education*”²⁹; an essential in the acquisition of good clinical practice and for the development of reflective skills needed for lifelong learning.³⁰ There are many definitions of feedback, but overall, it is suggested that it is a shared process between people that aims to provide insight into performance. It is established that effective learning takes place when there is a cycle of experience, reflection, thinking and planning before embarking on the experience again.³¹ Feedback is one of the most powerful influences on learning and achievement³² although this impact can either be positive or negative.³³ Patient feedback is instrumental in the measurement, maintenance and monitoring of safety and “*should be collected as far as possible in real time*”⁵

Carey et al.²² undertook a systematic review on the teaching and assessment of communication skills in dental undergraduate education in 2007, although published in 2010. Eleven studies were evaluated in this review, and all studies showed that communication skills improved with communication skill training. A range of teaching and assessment methods were used with simulated patients, role-play with faculty, problem-based learning sessions and didactic teaching. Carey et al. noted that although dental undergraduate students are in an exceptional position to garner feedback from their patients on their own individual strengths and weaknesses of their interpersonal communication skills, no study considered in this review had sought real patient feedback to assess students’ communication skills. This review recommended that “*patient input into assessment may help guide and shape learning*”²²

Applying a limit on articles from 2007, a further search was undertaken by the authors in February 2015 with the aim of identifying research on patient input to develop the communication skills of undergraduate dental students. Eight articles were identified.^{22,34-40} A content analysis was performed on the eight articles by identifying the study design, number and stage of education of participants, the type of intervention, the results, risk of bias and the limitations and relevance to this study. Three of the papers were not deemed relevant to this study; for example, they used simulated patients.³⁴⁻³⁶ Of the five remaining papers, one was the systematic review by Carey et al.²² The remainder focused on the development and trial of a patient communication assessment instrument.³⁷⁻⁴⁰ It was concluded that none of the papers addressed patient perceptions of providing feedback to students. However, Wener et al. noted that an important area of communication that was missing from the literature was “*whether the provider welcomed assessment and feedback*”.³⁷

Clearly, the literature recommends feedback from real patients on the communication skills of their treating dental student. Clinical educationalists are encouraged overall by this literature to utilise the value-added contribution of the patient to authenticate and maximise learning. However, no evidence was found in the dental education

literature on the issues real patients and students would face when asked to do this. Moreover, patients are not commodities to be exploited or used. To be truly collaborative, it is necessary to seek patients' views on whether and how they wish to be involved in clinical education and the provision of feedback to students. The aim of this study was to build on a limited body of evidence exploring the perceptions of patients and dental students on the giving and receiving of feedback about student communication skills. It will also heighten the understanding of the issues faced by patients and undergraduate dental students. In our institution, like many others, a patient-to-student feedback process was not in place prior to the study. The findings from this study will inform the development of this initiative and have relevance to other dental schools in the same position. In the future, patients can then be invited and supported to become educators in the development of dental students' communication skills. The findings may also have relevance to the training of communication skills for other healthcare professionals.

2 | METHOD

Qualitative methodology was used to answer the research question "What are the thoughts, feelings and perceptions of patients and dental students with respect to involving patients in giving feedback on dental students' communication skills during clinical encounters." Data were collected using focus groups, two with patients and one with dental students. It was felt important to involve patients themselves in the decisions concerning research methodology and patients were asked, after explanation of the study, to select focus groups or interviews as the preferred method of data collection. Focus groups were favoured by a ratio of 7:3 as they were felt to be less intimidating than interviews with security enhanced in a group and where other group members might trigger new thoughts. Focus groups were therefore chosen to gain a high-level rationalisation of the thoughts, feelings and beliefs of the target population and to elucidate their reactions to the research question.

The literature is fairly didactic on focus group size with eight to twelve participants being seen as the ideal.⁴¹ For this study, eight was selected as the preferred number. This was felt to be comfortable for

the participants, and the group interaction between eight participants would generate rich data and allow clarification of opinion. Any more participants could be overwhelming, unmanageable or repressive for quieter participants. The questions and prompts used in the focus groups are outlined in Table 1.

The study population were Year 2 dental students at an English dental school and the patients treated by these students in the academic year 2015 to 2016. Year 2 students were chosen over higher year students, as they were the first cohort of a new 5-year undergraduate dental programme. The Year 2 students were predominantly school leavers who would have had little experience of interacting with the public in a healthcare environment by nature of their age. Ethical approval was granted on 24 December 2014 by NHS REC (reference 14/YH/1316) and locally from the participating dental clinic.

Data analysis involved inductive thematic analysis using NVivo 10 (QSR International Pty Ltd. Version 10, 2014). This facilitated acquaintance with the data and through reading and re-reading the data, words used by participants were closely looked at and interpreted to what the data might mean by assigning metaphors to segments of text. These metaphors were used to create and assign codes to segments of text. These codes were reviewed and the relationships between these codes were sought to generate categories, which were then classified into to several subthemes, and then from this, general themes were identified. For example, the codes of "anonymous," "named," "identified" and "confidential" led to the category "anonymity." Data analysis revealed congruent and unique issues for both participant groups. The rigour of the research⁴² was tested by peer debriefing, triangulation and member checking with participants, participant validation of emergent themes, prior to final analysis, clear documentation of the rationale behind decisions taken during this research study and clear exposition of the research methodology and reflexivity of the challenges faced.

3 | RESULTS

Of the eighty patients who were invited to participate in the study, three of the five who volunteered for the first patient focus group attended and five of the fourteen volunteers for the second one

TABLE 1 Questions used in focus groups

| | |
|--------------------------------------|--|
| Engagement questions | <ul style="list-style-type: none"> I am going to show you the score sheet used to rate a dental student's communication skills when they are interviewed for their first year as a trainee dentist after qualifying to each participant. This shows you the different areas of communication skills that are looked at. Think about how you would feel if you were asked to give/receive feedback on these different skills. Could you let me know what you are thinking if you were asked to do this/receive this? |
| Exploration questions | <ul style="list-style-type: none"> What would make this hard for you to do? What would make this easy for you to do? Do you think this would be a good thing to do? |
| Exit question | <ul style="list-style-type: none"> Is there anything else anyone would like to say? |
| Helpful prompts the facilitator used | <ul style="list-style-type: none"> Can you talk about that more? Help me to understand what you mean? Can you give me an example? Thank you. What do other people think? |

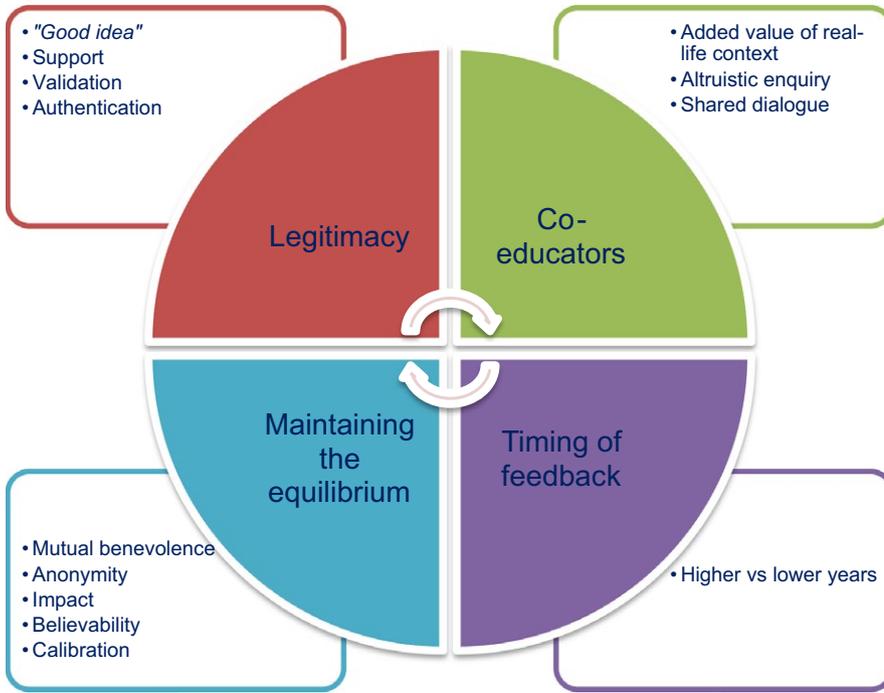


FIGURE 1 Themes from the data

attended. Repeating patient recruitment generated a recruitment rate of 10%, which although low gave a total of eight patient participants. Of the sixty students who were invited to participate in the study, ten volunteered to take part. As the attrition rate was unknown, all were invited and all attended. This was a recruitment rate of 17%. There was a self-selection bias towards female participants with six patient and seven student female participants, but males were represented with two patient and three student participants.

Four themes were drawn out from the data, shown in Figure 1.

3.1 | Theme 1: Legitimacy of patients as feedback providers

The first question explored at all focus groups was whether the participants agreed that patients should be involved in giving dental students feedback on communication skills. All patient participants and all but one student participant strongly felt patient communication skills was a "good idea." Although one student participant was undecided, the other students cajoled them into seeing the positives of this. This demonstrated a reconstruction of a view within a focus group;

Student 10: Maybe not all of us would want this patient feedback, like some of us would probably be quite happy to go along without like feedback from patients; I think it depends on the student's personality as well, if they can take on board like feedback like that and so I think it's just dependent on the person...

Student 7: But then if you're struggling to communicate with patients you're never going to find that out...

Student 3: At the end of the day if you can't take feedback you're never going to learn stuff.

Patients felt they were best placed to give feedback on students' communication skills and that "nobody else could do it." These were strong sentiments that gave legitimacy, as in the rightfulness, to patients being involved in giving feedback.

Patients however exhibited some vulnerability towards this, and to augment this legitimacy, they wanted support from clinical supervisors to give feedback to students and wanted faculty to have ownership of the process rather than themselves.

Patient 5: I think it needs to be a double-act of the patient and the supervisor.

They also want permission from faculty to give them the authority and validation to be authenticated in the feedback process in the first place.

Patient 4: Yes I think some patients may feel it's not their place to openly give feedback, and whether it's criticism or praise, because they feel you're in a practice centre really until that person becomes fully qualified and a professional, and I think sometimes patients might feel it's not their place to actually openly say anything.

Collectively, these observations strengthen the notion that patients and students perceive patient feedback could offer a valuable and unique insight into the students' communication skills. Nevertheless, this is not without concerns and supervisor and faculty agreement and support is needed to increase its acceptability.

3.2 | Theme 2: Co-educators

Patients have noticed a shift from the traditional paternalistic delivery of care in dentistry towards one where they are more involved and

have more influence on decisions taken. They are willing to embrace this shift and in return want to enhance the students teaching and learning experience through acting as co-educators.

Patients felt facilitating the added value of a real-life context prepared students for life after graduation.

Patient 8: I think the feedback that students generally would receive would be far more favourable than once they're qualified and out into the big wide world, cos when people are paying for a service they expect absolute top dollar service and nothing else will do, so I think maybe the students need to start thinking about when they're out in the big wide world that the paying public is not so forgiving.

Patients also perceived that by unselfishly encouraging students to demonstrate and verbalise their knowledge through altruistic enquiry increased students' confidence.

Patient 2: I sometimes feel that they're actually learning by me asking the question.

Patients also felt that there was an opportunity for shared dialogue that in turn made them feel more in control during their treatment and which enhanced students' proficiency in communication.

Patient 3: I suppose it's an advantage actually seeing the students is that you do get that opportunity to say what you feel because they always stop and they get somebody over so you can ask questions.

Patient 5: And there's also a thing about remaining in control of your own treatment isn't there, you know if you go to theatre now you're walked to the theatre instead of being taken in a wheelchair because the thinking is that you remain in control cos you're taking yourself, and I think it would be the same with this situation you know, you remain in control of your own treatment.

The opportunity for more time at each clinical encounter offered more patient autonomy during treatment.

Students did not comment on how patient feedback would help them individualise the patient and they did not recognise there would be potential benefits to patients engaging in feedback. Students saw feedback as a unilateral interchange to help them "work on their strengths and weaknesses" and "get into good communication at the patient's level".

3.3 | Theme 3: Maintaining the equilibrium of the patient-student relationship

Patients and students at a dental educational establishment have mutually beneficial roles; patients expect good free dental treatment in exchange for their time, and students use patients to practice and hone their clinical and interpersonal skills prior to graduation. To

maintain this relationship, both groups want to affiliate themselves in a harmonious relationship with the other group where there is equivalence of respect and a sense of a balance of power. Mutual beneficence may strengthen this interplay between the two groups whilst tensions may disrupt it. Maintaining the equilibrium of the patient-student relationship was fundamental to both groups, and influences were identified from the data that could affect this equilibrium. Both participant groups demonstrated mutual feelings of benevolence and compassion for the other group that strengthened the relationship, and both groups highlighted careful support of the students was needed if feedback was negative. Patients were concerned for "sensitive" students.

Patient 6: You're glad to give feedback; you just don't want to destroy their confidence...

Conversely, there were several anxieties that weakened this relationship. Disclosure issues around anonymity were bothersome for both groups. Impartiality was a difficult area for both participant groups to reconcile, and patients had mixed feelings on whether protecting their anonymity and maintaining confidentiality would help this. In the main, the patients were happy to be identified as the person giving feedback, but this was probably due to the majority having very favourable experiences so far with their dental students.

Patient 3: I would prefer that to be sort of anonymised I think because it depends so much on the student you've got.

Students were also of mixed opinion on this issue; they did not like the feeling of uncertainty, wondering whom the potential feedback provider was but were able to sympathise with the patients for wanting to remain anonymous.

The impact of patient feedback on future encounters was seen as potentially influential for both groups. Patients were concerned that giving negative feedback may be hard for some people in case the causal effect was inferior treatment. Students felt knowing a patient had given negative feedback would make them feel more insecure about their relationship with their patient, possibly effecting their competency during treatment.

Patient 5: I do appreciate that some people may, you know a concern about how will it affect their treatment if it's a negative comment, so I do take that on board that it might not be easy for some.

Student 7: Might make you worry about future treatment you're doing, make you a bit more self-conscious.

These influences on future treatment led both groups to perceive the believability and calibration of the feedback to be problematic. The question of truthfulness of patient feedback was raised as both groups were aware that the impact of adverse feedback might be harmful to the patient-student relationship.

Student 5: I do wonder though how honest a patient would be if they knew it was going to be fed back straightaway to their student.

Patient 2: it depends on your patient really, cos you don't really know the patient, you could have a patient that just flies off the handle, or one that tries and puts it in the nicest possible way.

Maintaining an equilibrium is challenging, and this was demonstrated in the conflicting areas within this theme.

3.4 | Theme 4: Timing of patient feedback

Both groups discussed the practicalities of implementing a patient feedback process, and one notable area of division between the two groups was the perception of where to place patient feedback within the dental programme. A difference in the timing of patient feedback in either higher or lower years was noted between the two groups.

Patients felt patient feedback is better in higher years (years 4 and 5) as they felt students were better equipped to manage the impact of this, being more mature and confident;

Patient 3: It's tricky, it depends which students you've got, I think if it's ones who were just in the second year, the first time they come across a patient that's very new... Or the fourth and fifth, they can handle it better, but I think for when they first start they're so under confident anyway.

And students wanted to learn as much as possible at the beginning of their programme and "get it right" early on.

4 | DISCUSSION

4.1 | Limitations

The heterogeneity of the participants is not described as age and ethnicity demographics were not registered to preserve anonymity. Participants self-selected to take part in the study as such may have different views to those less motivated to take part in research. The sample size was small, but not unusual for focus groups and qualitative methodology.⁴³ A limitation of qualitative research is that it is not possible to generalise the findings. However, the in-depth description of a small number of participants' views may resonate with readers. Contextual detail is given so that readers may judge whether the findings transfer to their own settings. The integrity of the data is demonstrated using two patient focus groups, triangulating findings with student views and member checking. The findings echoed those of Carey et al.²² and Lauckner et al.,¹² further enhancing the credibility of the study.

Strategies were put in place to improve response rate such as reimbursement of costs without incentivising payments, a personal contact by the researcher to allay concerns and highlight the importance of the study, and a simple-to-understand information sheet. Despite these

strategies, patient recruitment was a challenge. During recruitment, most people were willing to complete a questionnaire at the time but unwilling to return at a later date. Working people, in particular men, did not feel able to miss work to participate in research. It is not known why there was poor retention of patient participants with eleven failing to attend the focus groups and whether there were reasons around the research itself or around the burden of focus groups, and this is an area that needs further consideration.

4.2 | Discussion of findings

Dental education is about training the dentists of tomorrow to have the values and clinical skills necessary for collaborative patient-centred preventative and interceptive practice. Communication skills are critical to this, and good communication has multiple effects on oral health outcomes. A unique, deep, trustful relationship is built up over a period of time with opportunities to use communication for initial consultation, to discuss prevention, treatment options, risks and benefits of treatments, pain management and future recommendations. As dental students treat real patients early on in their education, they have a unique opportunity to engage in open discourse with their patients for their personal education. However, patients are not a commodity to be used without due care. It is imperative to understand the issues patients as important to be truly collaborative. The literature on teaching and assessment of communication skills in dental education suggests that "patient input into communication skills assessment may help guide and shape learning"²² Yet, no discussion in the literature was found in the systematic review of the perceptions of patients and dental students on these issues.

Whilst being the recipient of dental care at an educational establishment, patients might not necessarily expect to be involved in giving feedback on how a dental student communicates or see it as their place to do this in a learning environment. It is reassuring to know that the stakeholders involved are also supportive of this recommendation. Both patient and student groups indicated that patients were "best placed" to comment on the communication skills of dental students. In addition, patients, albeit based on a small self-selected sample, want to be involved in clinical dental education to improve patients' dental experiences in the future. This prosocial behaviour aligns with the aspirations of the DH¹ and NIHR² where patient involvement in clinical education is pioneered to improve patient care. This study did not however see students seeing the benefit of improved patient care from patient feedback, which was in contrast to the paper by Oswald et al.¹⁴ It resonates with the findings of Lauckener, Doucet and Wells¹² where "making valued contributions" was a clearly defined benefit of patient involvement.

This perception of patients being "best placed" and motivated to give feedback on communication skills gives legitimacy to the concept that it is rightful for patients to give feedback and to comment on students' communication skills. Whilst expressing this, concurrently, there was also some indication that patients did not necessarily expect to be involved in giving feedback on how a dental student communicates or see it as their place to do so. A recommendation to dental

educators is to provide clear statements giving permission and reiterating patient legitimacy in communication skill feedback processes. It is hoped this will overcome patient concerns and enable them to realise a position as valued stakeholders in the feedback process. This aligns with Berwick's goal of *"not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care"*⁵

Bleakley and Bligh suggest a constructive framework for clinical education where there is a shift from the traditional paternalistic viewpoint whereby the supervisor (as the teacher) communicates with the student (as the learner) with the patient providing a supportive role to one where there is a relationship between the patient (as the educator) and the student (as the educator and co-learner) with the supervisor having a supportive role⁴⁴ However, the patients in this setting are seen primarily as co-educators rather than patient educators and the supervisors as experts and supportive.

The participants contemplated how anonymity might undermine or enhance the equanimity of this valuable relationship. Anonymity may reduce patient bias and free the patient from psychological pressures and concerns about future impact. Evidence suggests, however, that anonymity is counterproductive in clinical settings as it does not prepare the student for employment, where complaints and negotiations with dissatisfied patients may occur. Additionally, it weakens the learning process by eradicating the opportunity for discussion between the two groups⁴⁵ Students may feel thwarted in the feedback process if they are not able to enter into discussions with the feedback provider. Notwithstanding this, if lack of anonymity is a crucial barrier to patients engaging in feedback, then this must be respected and anonymity maintained.

Ideally, feedback is criterion-referenced and students should expect to receive feedback based on mutually agreed criteria against which their performance will be assessed. It is important that students are aware of what is considered to be a good performance; otherwise, they will find it difficult to modify the gap between the actual level and reference level of performance⁴⁶ Yet, patient feedback may be highly subjective and unique to that student-patient relationship and encounter. This may impinge upon feedback how it is received. The participants recognised calibration of feedback as being a difficult area, and there was much discussion about the advantages and disadvantages of scoring charts, pictorial Likert scales, free-text boxes, websites, comment books or verbalisation as vehicles for delivering the feedback. This perhaps could be performed by capturing feedback from patients as they leave the dental clinics on a tablet app or by adapting the "Patient and Student Communication Assessment Instruments" to be more user-friendly^{37,38} Training patients to criterion reference feedback needs to be considered prior to implementation of patient feedback or an acceptance that patient feedback is formative and subjective. A consensus was not reached on how to implement a patient feedback system. Indeed that is beyond the scope of the project which set out to consider perceptions of patient feedback on dental students' communication skills. The data suggest that process and implementation of feedback systems are further areas for exploration.

Whatever process is used to gather and give feedback from patients to students, support for the provider and receiver of the feedback was requested to facilitate authentic feedback. The legitimacy of learning by permitting mistakes to be made should be supported¹⁵ In addition, timely feedback was desired. This aligns with the Friends and Family Test⁴⁷ and the Berwick report that suggest feedback is collected as far as possible in or near *"real time"*⁵

A further area of debate is when in the course to give students patient feedback on communication skills. The literature supports introducing patients in communication skill training after small group practice and role-play with standardised patients.^{22,35,48} The findings from the patients in this study support this view, and it is therefore recommended that patient feedback on communication skills is introduced in the higher years of a 5-year dental programme, allowing the simpler contexts to be addressed in the lower years. However, the student participants wanted to receive patient feedback early on in their dental education to *"get it right."* In addition, UK-based dental educators have a statutory requirement to fulfil the General Dental Council (GDC) learning outcomes for communication⁴⁹ and fulfil patients' expectations related to understandable communication as detailed in the GDC's "Standards for the Dental Team" document⁵⁰ In these, it states patients can expect to receive full, clear and accurate information that they can understand, before, during and after treatment, so that they can make informed decisions in partnership with the people providing their care. By involving patients in feedback on students' communication skills, they will be able to comment on whether their need for understandable communication is being met. This has relevance in courses where students see patients in the lower years.

The key recommendation from this study is to involve patients in providing feedback to dental students on the latter's communication skills. The study indicates a perception that patients are best placed to provide communication skill feedback and are motivated to do so. Information needs to be imparted to patients and students that capitalises on the notion of its mutual benevolence and legitimises it. However, the study is a small exploratory one and would be enhanced by further data collection. This will improve the credibility and transferability of these findings.

5 | CONCLUSIONS

This research was driven by national initiatives to involve patients in improving clinical education. Whilst espousing using patients to give feedback on dental students' communication skills, studies exploring how patients and students feel about this were absent in the literature.

Universal support for this proposition was established with patients thinking they were best placed to comment on the communication skills of dental students. This is in accord with the findings of the systematic review on patient involvement in medical education⁶ and the recommendations from the systematic review on teaching and assessment of communication skills in dental education²² The findings from this study show that patients and students are willing to engage in patient feedback on students' communication skills during clinical

encounters. With support and training, the concerns around this engagement are not insurmountable and the benefits mutually profit both groups. Consideration of the themes generated in this study could be used to empower patients and students to engage in this unique opportunity in a meaningful and constructive way.

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CONFLICT OF INTEREST

There are no conflict of interests and nothing to disclose from any of the authors.

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