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Assessing Communications Competencies through Reviews of Client Interactions and Comprehensive Rotation Assessment: A Comparison of Methods

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ABSTRACT

The primary purpose of this study was to compare two methods for assessing student communication skills: a labor-intensive review of video-recorded interactions and global communications assessment using a comprehensive rotation-assessment tool. Secondary goals of the study were to evaluate student strengths and weaknesses to inform the pre-clinical communications curriculum and to evaluate for consistency between types of reviewers. Video recordings of 43 student encounters with clients presenting their animals for wellness or diagnostic appointments to the primary care service at a veterinary teaching hospital were reviewed by one of three primary care clinicians, a social worker, and a clinical communications instructor, using a common rubric. Scores using the rubric were compared with overall scores for verbal communications on a comprehensive rotation-assessment tool, both for the primary care rotation and for other small-animal rotations. Duration did not vary significantly between wellness and diagnostic appointments, or between dog and cat appointments. Scores achieved by students on video review varied by evaluator, with the clinical communications instructor scoring students the lowest and the social worker scoring students the highest. Strengths identified included greeting the client appropriately, gathering initial information about the reason for the visit, and using lay terminology appropriately. Weaknesses included summarizing information for the client, talking to clients about money, and making strong recommendations.

Key words: veterinary, education, competency, communications, assessment

INTRODUCTION

Communications training is a requirement of veterinary curricula, as supported by the accreditation standards for North American veterinary colleges through the American Veterinary Medical Association Council on Education and as evidenced by presence of a significant number of communications-based items on the North American Veterinary Licensing Examination.[1,2] In a systematic review evaluating which professional non-technical competencies are most important to the success of graduate veterinarians, communication was the sole skill supported.[3] In a survey of over 1,700 veterinarians in the United Kingdom and United States, 98% of respondents rated communication skills as important or more important than clinical knowledge.[4]

Communications training in medicine is commonly assessed using some variant of the Calgary–Cambridge guide, as recommended by Kurtz et al.[5] Skills assessed in this system include building rapport, demonstrating empathy, gathering data using open- and closed-ended questions, breaking up and summarizing information, and clarifying client or patient understanding of the information and plans to move ahead. Client interviews to determine value of components of this system for veterinary clients demonstrated great value in building rapport, verifying that all of the client's questions have been answered, demonstrating empathy, and summarizing information.[6] Some skills are unique to veterinary medicine. These include interacting with the patient while maintaining communication with the client, appropriately selling veterinary services while being responsive to the client's emotional needs and financial considerations about decisions of care, and communicating about euthanasia.[7]

Many methods of communications training and assessment have been described.[8] Examples of assessment of clinical communications in the final year of training include simulations; objective structured clinical examinations (OSCEs), in which students interact with actors trained to perform as patients or clients; and clinical evaluation exercises (CEXs), which are direct observations of a student interaction with a patient or client. Authentic assessment through reviews of video-recorded client interactions in a teaching hospital has also been described,

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and this form of review is described by some as being particularly constructive for trainees.[9,10] Instructors perceive this exercise as very beneficial, particularly for students who may overestimate their communication skills on self-assessment.[10] However, review of video recordings followed by provision of direct feedback to students is resource intensive. Equipment must be installed to permit capture, archiving, and ready retrieval of client encounters. Faculty members must be trained in communications and in giving constructive feedback and they must be given time during the clinical rotation to review recordings and provide feedback to students. Many instruments for comprehensive rotation assessment already ask clinical instructors to evaluate and grade students on verbal communications so some faculty members may consider this more intensive evaluation to be redundant and inefficient.

The primary purpose of this study was to compare two methods for assessing student communication skills: a labor-intensive review of video-recorded interactions and global communications assessment using a comprehensive rotation-assessment tool. Secondary goals of the study were to evaluate student strengths and weaknesses to inform the pre-clinical communications curriculum and to evaluate for consistency between types of reviewers. The research questions for this study were as follows:

- Do students earn different scores when they are evaluated through an intensive assessment of client interactions using an itemized rubric than through a comprehensive rotation-assessment tool for verbal communications?
- Are scores for verbal communications on the primary care rotation for a given student consistent with scores for verbal communications earned on other small-animal rotations in the Veterinary Medical Center?
- What are the communications strengths and weaknesses identified in the authors' specific communications curriculum?

MATERIALS AND METHODS

Students on rotations at the Veterinary Medical Center of the University of Minnesota College of Veterinary Medicine are graded and receive broad feedback through an electronic comprehensive rotation-assessment tool (Appendix 1). All students on the primary care rotation choose one client encounter, either a wellness appointment or a diagnostic appointment addressing one or more specific problems in a dog or a cat, to be video recorded for review and discussion regarding their communication skills. A technician solicits client permission and saves a digital copy of the encounter in a secure folder. At some point during the 2-week rotation, one of the primary care clinicians reviews and scores the student's performance and then meets with the student to discuss the encounter.

The Institutional Review Board of the authors' institution approved this study. All raters used a common tool, which was an updated version of a rubric that had been developed and reviewed for validation years prior at the authors' institution (R. McComas and P. Dimock, unpublished) (Appendix 2). Raters met as a group to calibrate use of the scoring rubric. Three separate types of raters were included: (1) primary care clinicians, (2) a social worker, and (3) a clinical communications instructor. For the first group, any of the three primary care clinicians reviewed and scored a given student. A dedicated individual represented social work (AD) and another dedicated individual represented clinical communications instruction (MVRK). Student permission for inclusion of their video-recorded encounter in the study was obtained by a technician. A member of each group evaluated the video recordings from every other rotation for an entire clinical year for all students who had completed their first 3 years of training at Minnesota. Video recordings were evaluated during or immediately after the rotation during which they were captured. For the purposes of this study, scores were calculated as the percentage of affirmative responses from the total yes/no responses for a given student, excluding those responses marked "not applicable" or left blank. Scored sheets were stored electronically in a common file.

Data from the comprehensive rotation-assessment tool were compared to those from the grading rubric. Statistical analysis included descriptive statistics, ANOVA, and correlations calculated using Pearson's correlation coefficient (r). Significance was set at $p < .05$.

RESULTS

Complete video-recorded encounters were available for 43 students, 3 of which were male. Because so few students were male, no comparisons were made between female and male students. All appointments were seen with technicians who answered questions when directly addressed but who did not substantively participate in the client communications. Twenty-three were wellness appointments and 20 were diagnostic appointments to address one or more specific problems. Thirty-five appointments were with a dog and eight with a cat; no appointments were for more than one animal.

Overall average duration of student interaction with clients was 19.2 ± 5.7 minutes (mean $\pm$ *SD*). Average duration of wellness appointments was 20.0 ± 5.8 minutes and average duration of diagnostic appointments was 18.2 ± 5.7 minutes; this difference was not significant. Average time of cat appointments was 17.0 ± 3.6 minutes and average time of dog appointments was 19.7 ± 6.0 minutes; this difference was not significant.

Overall average score was 0.76 ± 0.11. Average score for wellness appointments was 0.78 ± 0.09 and average score for diagnostic appointments was 0.72 ± 0.12; this difference was not significant. Average score for cat appointments was 0.75 ± 0.11 and average score for dog appointments was 0.76 ± 0.10; this difference was not significant.

Specific items that caused students the least trouble, namely those with the lowest percentage of "no" ratings, were "greets client and pet" (0%), "elicits purpose of visit" (2.3%), "seeks permission before entering" (4.7%), "allows client to complete their opening statement without interruption" (4.7%), and "provides client with information about problems or situation using terms the client can understand" (4.7%). Specific items that caused students the most trouble, namely those with the highest percentage

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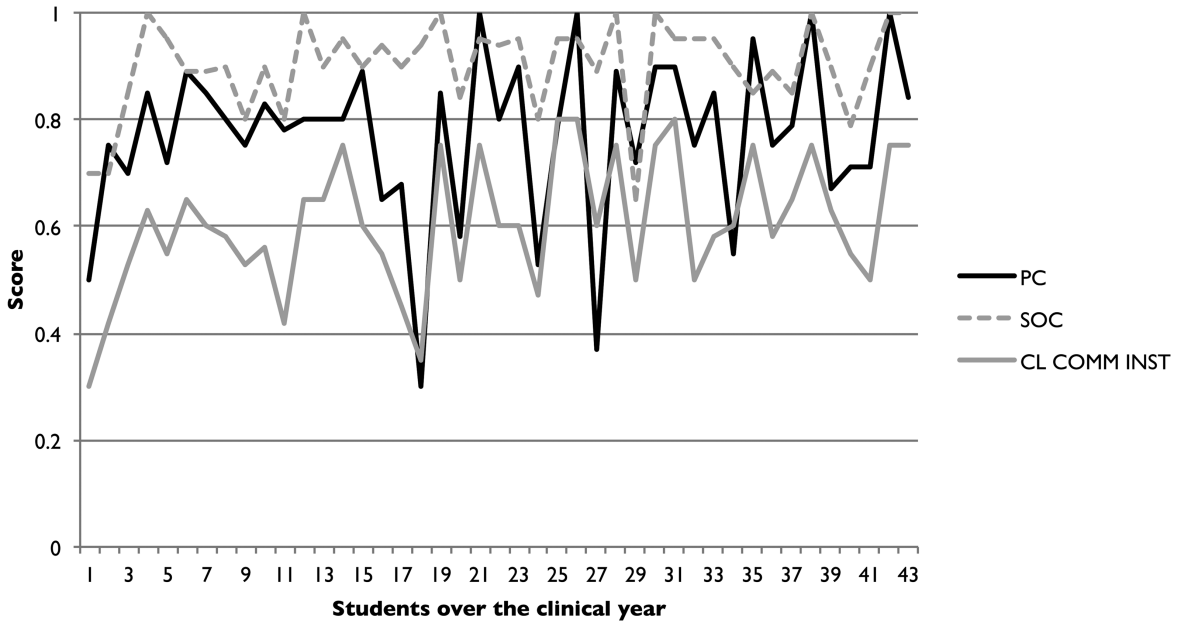

Figure 1: Variation in scores by rating group over the clinical year
PC = primary care clinicians; SOC = social worker; CL COMM INST = clinical communications instructor

of "no" ratings, were "discusses costs with the client for all recommendations" (58.1%), "confirms all client's concerns have been addressed" (46.5%), "reflects client's opening statement at any point in the encounter" (44.2%), "summarizes the information that's been gathered" (44.2%), and "makes confident recommendations" (37.2%).

Average score varied by student track, with small-animal track students ($n = 31$) scoring higher, at 0.79 ± 0.09, than all other students (equine/food animal/mixed animal, $n = 12$), who averaged 0.69 ± 0.10 ($p = .032$). Average score also varied by rating group ($p < .001$), with significant differences among all three groups ($p < .001$). The lowest scores were assigned by the clinical communications instructor (0.61 ± 0.12) and highest scores by the social worker (0.90 ± 0.08). The average score assigned by the primary care clinicians was 0.77 ± 0.16 (Figure 1). Scores did not differ significantly among the three primary care clinicians (SL 0.77 ± 0.09 [$n = 25$], KF 0.73 ± 0.13 [$n = 12$], HF 0.77 ± 0.09 [$n = 7$]). Scores increased over the year ($r = .26$ for all, $r = .12$ for primary care clinicians, .23 for the social worker, and .37 for the clinical communications instructor).

There was no significant correlation for students on primary care between their verbal communications grade for the rotation and their score for the client encounter ($r = .20$). There was a correlation between the verbal communications scores that students received on primary care and their average verbal communications score for the two small-animal rotations they completed before and after primary care ($n = 22$; $r = .73$).

DISCUSSION

Limitations of the study were the lack of randomization of video recordings over time for scoring and the lack of a suitable mix of male and female students to permit evaluation of differences by gender. The video recordings were scored in real time because the primary care clinicians were already completing those evaluations to provide students with feedback while they were on the rotation. Efficiency in completing this study without creating an undue burden of work for the primary care clinicians required that the primary care grouping be an amalgam of reviews by one of the three clinicians for each student. Clinicians reviewed video recordings as they were created rather than waiting to complete evaluations at a later time. Differences in communication skills have been identified between male and female veterinary students; this could not be evaluated in this study.[11]

In this study, there was no difference in duration of appointments by type. This supports what has been demonstrated in other studies.[12] In one study, despite the lack of difference in time spent in wellness and diagnostic appointments, independent raters reported that veterinarians appeared more hurried during diagnostic appointments.[12] None of the raters in the present study noted any observations of this type in the comments section of the rubric, but this particular point was not stressed during calibration of the instrument. In another study, clients reported that feeling rushed prevented them from having an ideal veterinary experience and that the appearance of the veterinarian having time constraints gave them the impression that the veterinarian was being less thorough.[6] It is important to stress to students the importance of being fully present for each appointment to reassure the client that they have the student's full attention.

The most common problems identified in one study using authentic student–client interactions as a communications teaching tool were lack of eye contact, not

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removing barriers to communication, not expressing empathy, not clarifying medical terminology, and not using open-ended questions.[10] In another study, students reported feeling most confident in building rapport, displaying empathy, listening, and recognizing the extent of the human–animal bond between client and patient.[13] In the present study, students did a good job of welcoming the client, gathering information about the presenting complaint, and talking to clients in a manner they could understand. Students had the greatest difficulty talking to clients about money, making confident recommendations, and summarizing information. These difficulties were not surprising. Discussions with clients about cost are very concerning to veterinary students, to new graduates, and to practicing veterinarians, with small-animal practitioners less and less likely to have discussions about cost the longer they have been in practice.[13–15] In a review of 200 small-animal appointments, only 29% included any discussion of cost and only 14% included reference to an estimate.[15] Clients want to know all of the options when making decisions for their pet, and 81% of clients in one study reported wanting to know costs and incorporate this information into their decision-making process.[16,17] Clients expect veterinarians to help them understand costs relative to outcomes for their pet's health and well-being.[18] Veterinarians report hesitance in discussing costs because they are sometimes made to feel guilty by clients for the amount they charge or feel undervalued when clients question costs of care.[16] This may be because veterinarians tend to focus communications about cost on the direct costs of time and services, rather than focusing on the value the client and their pet will receive for services offered.[18]

In one study, a direct link was identified between how well the client perceived the veterinarian to have communicated and the likelihood that they would follow their veterinarian's recommendations.[17] Clients value the veterinarian's summary of data.[6] Students are conscious of the need to use time efficiently and they may not be prepared to prolong conversations with clients by taking time to summarize. Cognitive load theory, which theorizes that humans can only handle five to nine items in working memory at a time, suggests that students, as novice learners, may be unable to summarize because they cannot readily chunk information into groups at any given time to decrease the number of data points collected from the history and physical examination.[19]

Students in this study also struggled to give confident recommendations. In a study evaluating likelihood of client compliance with recommendations for surgical or dental procedures, clients were most likely to comply if the recommendation was straightforward and the client understood the reason behind the recommendation.[20] An example of a strong recommendation in the context of this study would be, "You take Fido up to your lake cabin in northern Minnesota regularly, and we know the incidence of Lyme disease is higher in that area because of the presence of deer ticks. He should be vaccinated for Lyme disease because he is at greater risk and we also should talk about tick preventative." Students in this study often gave more indirect recommendations, perhaps perceiving them as less pushy and more polite. An example of such an indirect recommendation would be, "We do see Lyme disease in Minnesota and we might want to talk about vaccinating Fido for that at some point."

Students with a small-animal emphasis during their clinical year scored higher than did students in other clinical tracks. This may be because the primary care service strives to mimic general practice, in which most of the small-animal track students have experience.

It is well acknowledged that scoring of communications assessments is subjective and therefore more difficult to perform in a consistently valid and reliable manner than assessment of technical skills or knowledge.[8] Sources of error may include the scoring instrument itself, including length of the instrument, clarity of items to be scored, and joint understanding of the scale used; the sample, including characteristics of the students being evaluated; and the conditions of administration, including the time of day, distractions at the time of scoring, and fatigue of the person doing the scoring.[21] A recent review described common rater errors in clinical performance assessment.[22] Those potentially occurring in this study are listed in Table 1. In one study comparing scores of faculty members with those of actors trained as standardized clients and trained in use of a specific assessment tool, no difference in scores was identified.[23] In a study evaluating whether background of evaluators of OSCEs affected their scoring, there were significant differences in scores assigned by clinical science faculty members, basic science faculty members, faculty members who teach clinical communications, and hospital administrators/technicians, with those faculty who teach clinical communications assigning lower scores.[24] In the present study, it was also the clinical communications instructor who consistently scored students the lowest and it was the social worker, one of whose primary roles is to provide student support, who rated students the highest. It is interesting that the primary care clinicians, who had to meet with the students to describe and perhaps to defend their scores, were most moderate in their scoring.

The comprehensive rotation-assessment tool used for small-animal rotations at the authors' institution appears to be used consistently as a global measure of verbal communications, but it does not provide discrete enough feedback to readily permit students to identify specific deficiencies in communication for their own development. The expense of equipping examination rooms with appropriate equipment and the required time and effort spent by clinical instructors in their own training and in reviewing videotapes and providing feedback to students is justified by the value of the results. In human medicine, it has been demonstrated that skills learned during medical training are those that physicians carry forward, and that these skills remain strong for years after students complete their training.[25,26] Those skills they are somehow expected to master while "on the job" are rarely used, and competency in those skills is not attained.[26]

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Table 1: Common rater errors

Name of effect	Description
Assimilation effect	The rater does not want to appear too extreme and so tempers his or her desire to rate items very high or very low.
Carryover effect	The rater is affected positively by great previous student or is affected negatively by poor previous student.
Cheerleader effect	The rater gives everyone high scores as a way of showing support for students.
Fatigue effect	The rater's scores are affected by overall fatigue or lack of engagement in the activity.
Favoritism effect	The rater overlooks mistakes or flaws because he or she likes the student as a person.
First impression effect	The student excels early on and the rater fails to adjust scores as performance declines over time.
Length effect	The rater scores higher for very short or very long performances, regardless of quality of the performance.
Personality clash effect	The rater puts too much weight on mistakes or flaws because he or she dislikes the student as a person.
Rater competence effect	The rater is not using the scoring tool correctly, for example, scoring when "not applicable" would be more appropriate.
Similar-to-me effect	The rater assigns higher scores to students who perform tasks as the rater would.
Skimming effect	The rater assigns scores without attentively watching all of the performance.
Sympathy effect	Some other aspect of the performance sways the rater to raise scores for poor performance.
Sudden death effect	The rater identifies one item that carries so much weight that poor performance in this one area drops all other scores.
Trait effect	The rater identifies one item that carries so much weight that good performance in this one area raises all other scores.

In the near future, all small-animal track students will be required to take the primary care rotation twice. This will give the primary care clinicians the opportunity to provide feedback for student communications training during the first rotation, to assist students in setting realistic goals, and to reassess those specific skills on the second rotation. This method of assessment and practice has been correlated with significant improvement in student performance in communications.[27] Addressing student difficulties discussing money, making strong recommendations, and summarizing information will permit clinical communications instructors in the pre-clinical curriculum to stress these problem areas and provide students with more opportunities for practice, hopefully improving their skills as they reach the clinical year.

Several studies have demonstrated a correlation between more opportunities for communications training and increased student comfort in having difficult conversations.[28,29] In one study, students who had completed more communications training generated higher average transaction fees as practicing veterinarians than did classmates who had not elected advanced training.[28] This suggests that increased practice and training in communications in general, and particularly regarding having difficult conversations, could increase practitioner confidence and revenue generation, as well as increase client compliance.

This study identified value in the labor-intensive method of communications assessment. The results of these assessments can enhance curricular development for pre-clinical communications training and provide students with more detailed feedback as they practice clinical communications.

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APPENDIX 1: COMPREHENSIVE ROTATION ASSESSMENT TOOL

Letter Grades at the University of Minnesota College of Veterinary Medicine

A	=	Outstanding. Consistently meets the highest level of expectation; has an excellent knowledge base; takes an active role in the rounds; demonstrates knowledge through full participation; has an excellent ability to integrate and apply knowledge; mature, compassionate, dedicated, skillful, and committed; demonstrates excellent teamwork; and exceeds timely performance of tasks.
B	=	Good to very good. Has a good to very good grasp of the information; has a solid ability to organize information, integrate, and make sound decisions; handles stress well; demonstrates compassionate and skillful patient care; and demonstrates consistent, timely performance of tasks.
C	=	Competent. Acceptable performance; has knowledge gaps; has adequate organizational skills; shows acceptable ability to work through a problem, integrate, and apply knowledge; struggles with handling stress and with human interaction; displays competent patient care.
D	=	Deficient. Has moderate knowledge gaps, which may compromise patient care; is somewhat disorganized, indecisive, confused, and disjointed; is marginally able to handle stress; is somewhat immature, and has difficulty with human interaction; and may miss deadlines.
F	=	Failing. Has significant knowledge gaps, greatly compromising patient care; is very disorganized, indecisive, confused, and disjointed, showing great difficulty working through obvious issues; exhibits serious problems in human interactions and ability to deliver patient care; and consistently misses deadlines.

General Rotation Evaluation

1: Knowledge: knows how and is willing to show how

Sources of knowledge Data gathering/ acquisition	**A**	Has exceptional knowledge of where to look for sources to obtain information and uses that knowledge with savvy.
		Demonstrates excellent knowledge of scientific literature relevant to cases under his/her care and accurately interprets this information.
		Actively gathers specific and relevant information from a variety of sources (e.g., history/physical exam, use and selection of appropriate tests and diagnostic modalities, timely history taking) to fully understand the problem.
	F	Is often confused about where to look for sources to obtain knowledge and may not know how to use that knowledge in an astute manner.
		Is unaware of scientific literature relating to his/her clinical cases and/or is unable to accurately interpret this information.
		Seeks limited additional information to better understand problems; jumps to conclusions at times when gathering additional information is appropriate.

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Basic knowledge	**A**	Excels at demonstrating technical knowledge specific to the rotation and the application of clinical skills. Has a strong understanding of what he/she knows and does not know. Shows exceptional logic and knowledge in written interpretations and histories, case reports, discussion with faculty, and links observations from assessments to plans/discharge notes.
	F	Fails to demonstrate technical knowledge specific to the rotation and the application of clinical skills. Has a basic understanding of what he/she knows and does not know. Presents only limited logic and knowledge in written interpretations and histories, case reports, discussion with faculty, and links observations from assessments to plans/discharge notes.
Species knowledge	**A**	Demonstrates complete knowledge of species-specific information of species encountered in rotation (e.g., behavior, nutrition, handling, etc.).
	F	Lacks knowledge of species-specific information of species encountered in rotation (e.g., behavior, nutrition, handling, etc.).
Disease processes	**A**	Demonstrates complete knowledge of pathophysiology, etiology, epidemiology, immune response, etc. of diseases encountered in rotation.
	F	Lacks knowledge of pathophysiology, etiology, epidemiology, immune response, etc. of diseases encountered in rotation.
Rotation-specific material: knowledge (please describe) **Comments: (please add any comments regarding student's knowledge here)**		

2: Clinical skills: applying the know-how in a practical setting

History taking	**A**	Demonstrates efficiency, thoroughness, and accuracy in history taking. Demonstrates ability to ask questions that are systematic, relevant, precise, objective, non-leading, and interactive with respect to information obtained. Asks clarifying questions and corrects inconsistencies. Organizes historical information accurately in the medical record.
	F	Is unable to gather history data in an efficient, thorough, accurate manner. Does not ask relevant questions. Uses leading questions. Does not ask questions of clarification. Unable to organize history data accurately in the medical record.
Physical examination	**A**	Demonstrates proficiency in performing a complete physical examination with efficiency, thoroughness, and accuracy. Accurately identifies and records normal and abnormal findings.
	F	Is unable to perform a complete, thorough, accurate physical examination. Misses significant findings. Does not recognize normal and abnormal findings.
Clinical decision making (includes assessment of information)	**A**	Displays outstanding ability at integrating relevant information to make sound clinical judgments (e.g., information from history, physical exam, lab data, imaging data, production data, scientific literature, etc.). Formulates a complete problem list, accurately prioritizes problems, and accurately determines differential diagnoses. Makes appropriate modifications in response to change in patient status. Takes economic considerations (e.g., cost implications of decisions, making wise choices that make sense in terms of treatment and cost) at a level appropriate for a senior student.
	F	Fails to integrate important clinical information, resulting in poor clinical judgment (e.g., history, physical exam, lab data, imaging data, production data, scientific literature, etc.). Is unable to formulate a complete problem list, prioritize problems, and/or determine differential diagnoses. Does not make appropriate modifications as patient status changes. Fails to take economic considerations (e.g., cost implications of decisions, wise choices that make sense in terms of treatment and cost) when making decisions.

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Diagnostic plan	**A**	Devises excellent diagnostic plans based on a strong knowledge base. Provides superior explanation and rationale for the diagnostic plan; explains the diagnostic plan in the context of a specific patient.
	F	Devises inadequate or incomplete diagnostic plans. Fails to provide clear explanation and rationale for the diagnostic plan; does not explain the diagnostic plan in the context of a specific patient.
Treatment plan	**A**	Devises complete and accurate treatment plan. Provides superior explanation and rationale for the treatment plan; explains the treatment plan in the context of a specific patient.
	F	Devises inappropriate or incomplete treatment plans. Fails to provide clear explanation and rationale for the treatment plan; does not explain the treatment plan in the context of a specific patient.
Organization of information	**A**	Organizes information in a very systematic manner (e.g., discharge notes, POMR, etc.).
	F	Fails to organize information in a reasonable manner.
Procedures/basic clinical skills	**A**	Demonstrates superior technical skills and is thorough and efficient in obtaining histories, performing physical exams, specialty examination skills, animal handling; is adept at basic procedures (e.g., drawing blood, inserting catheters, tissue handling, use of basic instruments, use of aseptic techniques, etc.).
	F	Demonstrates limited basic technical skills and is incomplete and inefficient at obtaining histories and performing physical exams, specialty examination skills, animal handling. Is not adept at basic procedures (e.g., drawing blood, inserting catheters, tissue handling, use of basic instruments, use of aseptic techniques, etc.).
Patient care and welfare	**A**	Provides excellent patient/client care. Pays vigilant attention to details, such as patient's comfort and nutrition. Ensures that treatments are done in a timely and accurate fashion. Readily recognizes changes in the patient's condition and communicates changes to supervising clinicians.
	F	Provides substandard patient/client care. Does not consistently look after patient's comfort. Does not consider patient's nutritional care. Inconsistently administers treatments or provides inadequate treatment. Fails to recognize and report important changes in patient's condition to supervising clinicians.
Documentation and written communication	**A**	Prepares medical records in an accurate, timely, and efficient manner; adept at using the "system" to enter medical records. Puts great effort into clearly communicating and documenting discharge information. Consistently writes in a constructive and professional manner; adapts writing depending on the reader (e.g., documents for other DVMs vs. client discharge records).
	F	Tends to prepare medical records that are inaccurate/substandard, not timely or efficient; is not adept at using the "system" to enter medical records. Makes no particular effort to clearly communicate and document discharge information. Writes in an unclear, confusing manner that is hard to follow; fails to adapt writing depending on the reader (e.g., documents for other DVMs vs. client discharge records).
Rotation specific material: clinical skills (describe) **Comments: (add comments regarding student's clinical skills here)**		

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3: Professionalism: work habits, interpersonal maturity and skills, teamwork, commitment, initiative

Attendance and punctuality	**A**	Is always present and on time (with the possible exception of a true, documented emergency). Always performs tasks in a timely fashion and meets deadlines.
	F	Does not meet attendance guidelines on syllabus. Has more than the allowed number of absences for the rotation. Consistently arrives late to sessions. Consistently misses deadlines.
Initiative and acceptance of responsibility	**A**	Willingly takes responsibility and ownership for own actions and their consequences (e.g., seeks feedback, willingly admits mistakes).
		Proactively follows up and follows through on cases (pending data, response to treatment, etc.).
		Always responds to ethical dilemmas in accordance with AVMA and legal standards.
		Readily assumes responsibility for equipment care and cleanliness. Cleans up after self.
	F	Avoids responsibility for own actions and their consequences (e.g., deflects blame, does not admit mistakes, resists feedback).
		Fails to follow up and follow through on cases (pending data, response to treatment, etc.).
		Demonstrates behavior that is not in alignment with ethical with AVMA ethical standards and/or legal requirements.
		Consistently fails to assume responsibility for equipment care and cleanliness. Does not clean up after self.
Teamwork, enthusiasm, and attitude toward work	**A**	Demonstrates excellent teamwork skills; works cooperatively with VMC personnel and clients.
		Conveys an exceptional "can-do" spirit, a sense of optimism, ownership, commitment, and dedication.
	F	Consistently demonstrates poor teamwork skills; does not work cooperatively with VMC personnel and clients.
		Demonstrates a consistent sense of pessimism and/or lack of ownership, commitment, and dedication.
Professional appearance	**A**	Always dresses in a professional manner. Adheres to dress code. Exhibits excellent personal hygiene.
	F	Tends to be casual in attire. Does not adhere to dress code. May have hygiene issues.
Work ethic and dependability	**A**	Exceeds commitments made to others (e.g., doctors, staff, clients).
	F	Frequently commits to things without following through, causing trust to be questioned.
Care of equipment and room	**A**	Readily assumes responsibility for equipment care and cleanliness. Cleans up after self.
	F	Consistently fails to assume responsibility for equipment care and cleanliness. Does not clean up after self.
Following instructions	**A**	Always actively participates and asks questions to clarify assignments/priorities and carries out tasks as expected.
	F	Puts limited effort into asking questions to clarify assignments/priorities and/or consistently deviates from the instructions.

Verbal communication	**A**	Displays excellent communication skills with clients, peers, faculty, and staff, including the ability to initiate communication, gather information, build relationships, give information, and close communication. Takes great care to demonstrate/communicate empathy and compassion.
	F	Displays substandard communication skills with clients, peers, faculty, and staff. Has trouble initiating communication, gathering information, building relationships, giving information, or closing communication. Consistently deficient in demonstrating/communicating empathy and compassion.

Rotation specific materials: professionalism (describe)
Comments: (add comments regarding student's professionalism here)

APPENDIX 2: SCORING INSTRUMENT

Student name: **Rater name:**

[ ] Wellness exam [ ] Diagnostic exam

1.	Seeks permission before entering. "No" is selected when student enters exam room before client acknowledges permission (either by knocking or peeking in).	Yes	No	N/A
2.	Introduces him or herself and identifies role as the fourth-year veterinary student. "Hi, I'm me and I'm the fourth-year student who will be working with you and Felix today."	Yes	No	N/A
3.	Greets client and pet (if present). Shakes hand if offered, smiles, makes eye contact.	Yes	No	N/A
4.	Positions him or herself at equal height with client. If client is sitting, student sits before going on. If client is standing, student offers the client option to sit.	Yes	No	N/A
5.	Engages the client on a personal level, if appropriate. Engagement is something other than a reference to the pet's presenting issue or an inquiry about the health status of the pet (e.g., "Kudos to you for Buffy's weight loss" or engagement with a child if present).	Yes	No	N/A
6.	Elicits purpose of visit. For example, "What brings you in today?" or "How is Lady doing?" If client states purpose before student has an opportunity to ask, student receives a "yes."	Yes	No	N/A
7.	Allows client to complete his or her opening statement without interruption (verbal statements that do not stop the client's flow of information [e.g., "okay"] are not considered to be interruptions).	Yes	No	N/A
8.	Reflects client's opening statement at any point in the encounter. "You're very concerned about how Lucky is doing and you're wondering when you will know the right time to put him down."	Yes	No	N/A
9.	Confirms all client concerns have been elicited. For example, "Did I miss anything?" or "Is there anything else?"	Yes	No	N/A
10.	Uses signposts to move to next section. Alerts client to the next phase of the consultation (e.g., "Now that we have a good idea of what your concerns are, let's go on and address them in their order of importance").	Yes	No	N/A
11.	Gathers information by using open-ended questioning techniques at least once.	Yes	No	N/A
12.	Acknowledges client's verbal and/or nonverbal expression of emotion, concern, or distress (emotions may be positive or negative).	Yes	No	N/A

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13.	Summarizes the information that's been gathered (may include information from the history and/or physical examination). For example, "Let's see if I have this right. Marlin can't stay at your home, you don't have any friends or family that he can stay with, and you prefer to have him stay in a facility?"	Yes	No	N/A
14.	Provides client with information about problems or situation using terms the client can understand.	Yes	No	N/A
15.	Makes confident recommendations. For example, vaccines, preventatives, laboratory tests, etc.	Yes	No	N/A
16.	Discusses costs with the client for all recommendations.	Yes	No	N/A
17.	Confirms client understanding of information provided (does not require verbal response from client). For example, "Is there anything I mentioned or anything I didn't mention that you have questions about?"	Yes	No	N/A
18.	Confirms client's decision about how to proceed. Confirms initial plan.	Yes	No	N/A
19.	Confirms all the client's concerns have been addressed.	Yes	No	N/A
20.	Brings consultation to a close. Explains the steps involved in the process of the consultation. Establishes realistic expectations for what can be achieved by the end of the consultation.	Yes	No	N/A

Comments:

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