

# Effective communication training to support person- and whānau-centred care: what is needed and why isn't it happening?

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## ABSTRACT

**AIMS:** We sought to investigate the current state of education to support person- and whānau-centred care (PWCC) in our setting and to inform a new approach to teaching and learning. Additionally, we investigated the potential use case of an artificial intelligence (AI) tool to enable clinical communication skill development.

**METHODS:** A mixed-method co-design approach was used, combining data from a consumer group, an anonymous staff survey (n=312) and a clinician focus group. The project captured lived experiences of communication in clinical care, enablers and barriers to effective training, and perspectives on future educational innovations including AI.

**RESULTS:** Consumers emphasised the importance of individualised, culturally safe communication and clear, jargon-free language. Findings confirmed that while clinicians generally gain confidence with experience, existing training in communication and PWCC is inconsistent and often inaccessible. Clinicians identified a need for more frequent feedback and practical opportunities for skill development. This feedback should be from a person and whānau perspective. Notably, 90% of clinicians expressed openness to using an AI-based tool for improving communication skills.

**CONCLUSION:** Traditional workplace education models are insufficient to meet the growing need for effective PWCC, including culturally safe communication in healthcare. An AI-enabled, feedback-driven tool may present a viable complementary solution to current offerings, provided it is co-designed with consumers and clinicians, is culturally grounded and is integrated into existing systems. Further investigation into the development and validation of a tool is warranted.

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Studies show that better communication improves health outcomes, safety and equity, while reducing costs.<sup>1,2</sup> Conversely, communication issues contribute to 80% of patient harm events.<sup>3</sup> Health Quality & Safety Commission Te Tāhū Hauora's recent national patient experience survey shows that Māori rate their communication with healthcare providers lower than other ethnic groups, including feeling uncomfortable asking questions.<sup>4</sup> This hampers shared decision-making and affects health outcomes and equity. Māori still experience poorer health outcomes and shorter life expectancy compared to other New Zealanders.<sup>5</sup>

Patient-centred care focusses on respecting individual preferences and ensuring that clinical decisions align with patients' values. It is a partnership between practitioners, patients and their families, empowering them with the education and support needed for informed decision-making.<sup>6</sup> For this report, we use the term "person- and whānau-centred care" (PWCC), which emphasises

the importance of recognising the whole person, not just their symptoms or disease, and the role of whānau in Māori health and decision-making<sup>7,8</sup> and of family in Pacific people's health<sup>9</sup>. PWCC is central to the 2022 Te Pae Tata Interim New Zealand Health Plan and is supported by the Health and Disability Commissioner's regulations, which protect patient rights, including the right to respectful, informed care and shared decision-making.<sup>10,11</sup>

People possess a unique understanding of the impacts of their current health and their future functional needs, which is vital to the clinical decision-making process.<sup>13</sup> Effective communication is therefore essential to PWCC, ensuring a two-way sharing of information that explores the patient's values and preferences and supports people and whānau to make decisions based on these.<sup>13,14</sup>

In 2020, the leading causes of death in New Zealand were cancers, ischaemic heart disease, stroke and chronic lower respiratory diseases.<sup>15</sup>

These conditions are largely modifiable, but effective prevention requires a health system that actively involves patients and their whānau in decision-making.<sup>16</sup> This approach depends on health professionals' attitudes, behaviours and their ability to support behaviour change through PWCC.<sup>16</sup> While clinician bias and inherent stereotyping of patients can contribute to poorer quality of care for some, quality of care is also reliant on a system that supports behaviour change: recognising that social determinants also have significant impact on health outcomes.<sup>17</sup>

One challenge to PWCC is the level of health literacy in New Zealand, which the World Health Organization defines as the ability to access, understand and use health information to promote well-being.<sup>3,5,13</sup> Health literacy varies depending on the situation, and low health literacy is linked to poorer health outcomes, particularly among Māori.<sup>18,19,20</sup> Despite tools to improve health literacy and communication, the implementation of these tools in clinical practice remains inconsistent.<sup>5</sup> Healthcare professionals often lack adequate training in communication skills that support PWCC and shared decision-making, including plain language to support health literacy.<sup>5</sup> While some education exists, it is often insufficient or not transferred effectively into practice.<sup>5,13,21,22</sup> Factors such as time constraints, tool familiarity and the de-prioritisation of communication training contribute to this issue.<sup>23</sup>

Simulation-based education is widely used in healthcare, generally including reflection or feedback. Practice and supportive feedback are key to developing skills, with feedback being most effective right after a learning event.<sup>24,25</sup> At Health New Zealand – Te Whatu Ora (HNZ), beyond basic graded clinical escalation training, there is often no mandated communication education, despite known risks to patient safety and health equity. Clinical demands often hinder participation in any training, indicating the need for accessible, motivating and effective education strategies. This places the onus on teaching and learning in the workplace. Clinical teachers themselves identify time as a key barrier to coaching in the workplace.<sup>26</sup> The effectiveness of the current apprenticeship model of clinical education has been brought into question.<sup>27</sup>

Artificial intelligence (AI) shows promise in healthcare communication training by offering cost-effective, time-efficient and accessible learning tools.<sup>28</sup> Evidence-based virtual patients can safely help learners build communication skills, while

supporting development in person-centred care and shared decision-making.<sup>29,30</sup> AI models have the potential to provide a more accessible learning platform that provides clinician learners with feedback and support to grow their capabilities in PWCC and shared decision-making.

## Methods

This project was a quality improvement project initiated in 2024 with staff from HNZ and Te Herenga Waka—Victoria University of Wellington on the project team. Research ethics approval was granted by the Human Ethics Committee of Victoria University of Wellington (#31569). The project was funded via Te Titoki Mataora Rapid Acceleration Programme (RAP)1 funding. The project team included consumers, clinicians, the HNZ New Technology and Innovation Manager, a health literacy researcher, AI researchers and representatives from Microsoft.

We took a mixed-method co-design approach utilising a clinician survey and focus groups with consumers and clinicians. We enrolled a non-clinical patient navigator alongside four consumers from the HNZ Consumer Engagement Group who represented Māori, Pacific, older adult, youth, rainbow and disability groups. They engaged in a structured group interview utilising an appreciative enquiry approach. An analysis was completed by two of the clinical project team members and the outputs were then reviewed and endorsed by the consumers themselves.

An anonymous clinician survey was sent to all clinical staff via the chiefs of medicine, nursing, and allied professions; education teams; and senior nursing groups. This gave us a degree of confidence that we were considering all views of the problem we had identified in the literature as they applied to our context, and the desirable features of a potential learning solution.

Twelve clinicians with particular interest in the project, or skills and interest in clinical communication education, were invited to participate in a focus group. Three of the consumers and six of the project team members also attended. With representation from nursing, medicine and allied professions, we facilitated a structured presentation of the data gathered via the consumer focus group and the clinician survey and used the session to further understand and discuss the topic. An analysis was completed by two of the clinical project team members and the outputs were then reviewed and endorsed by the clinicians who

attended the focus group.

## Results

### Consumer respondents

The consumers were asked to describe “good” communication in health interactions with clinicians. Scenarios were used, and they reflected on their own experiences. The appreciative inquiry approach taken provided qualitative data to help guide the learning solution design. In particular, cultural safety, the language and words used, and the need for individualised approaches to communication were highlighted. The focus group outputs were categorised and supported the findings from the literature as outlined below.

1. **Communication is individualised:** Each person’s communication needs depend on their values, beliefs and emotional state (e.g., feeling unwell, stressed or in pain).
2. **Building connection is important:** There is no single communication method that works for everyone. Building a personal connection is crucial for encouraging questions, aiding understanding and supporting shared decision-making.
3. **Clear language is essential:** Many people still struggle with medical language. Using simple, accessible terms, such as those recommended by the *Health Literacy Universal Precautions Toolkit*, can help improve communication.
4. **Empowerment to ask questions:** People want to feel comfortable asking questions and accessing the information they need without feeling judged or uninformed.
5. **Cultural sensitivity:** Recognise and respect cultural differences in communication styles and expectations.
6. **Power dynamics in healthcare:** The power imbalance between clinicians and patients is especially significant in cultures where respect for authority is emphasised. In such contexts, involving patients and their families in decision-making may require working within existing hierarchical structures.
7. **Transparency about health information:** Being open about diagnoses, prognosis and treatment options is important, but the approach to delivering this information should be tailored to each individual’s needs.

When the potential use of AI to coach and provide feedback on communication to clinicians was discussed, concerns were raised about the realism of AI and whether it could truly provide a consumer’s perspective. However, if this concern could be allayed, and given the gap in learning opportunities identified in the literature, the group felt there was a potential benefit to a tool for providing feedback on communication from a PWCC perspective; in particular, a tool to support clinicians to create a connection and develop some understanding of what communication methods will be effective for specific people and whānau, and more importantly establish an environment of trust where patient/whānau are able to communicate what their needs are. Feedback on the language used was also seen as critically important.

### Clinician survey respondents

The clinician survey has given the project team a picture of learning experiences from undergraduate level to current-state in our district. This is broken down by key topics below with some consideration of the demographics of the workforce.

Three hundred and twelve clinicians responded to the survey from most disciplines and across all ages and levels of experience. This corresponds to approximately 4% of the current clinical workforce in this district. Of the respondents, 84% were women, 14% were men, 2% preferred not to say and 1 person identified as non-binary. Tables 1–2 and Figure 1 describe the demographics of the respondents. The key survey results are described in Figures 2–8.

The self-reported ethnicity of the clinician respondents differs from the ethnic profile of the New Zealand and the Capital, Coast and Hutt Valley (CCHV) population. Unfortunately, due to an inability to access data from the human resources department, we are unable to compare these data to our workforce demographic profile.

Although newer graduates are more regularly receiving this education at undergraduate level, only 44% of senior clinicians reported to have received undergraduate education in relation to PWCC or shared decision-making themselves. Although this relies heavily on memory, it speaks to their perception of being taught and learning these skills at an undergraduate level.

Figures 5–7 indicate that accessing education when it is available is not easy for most (61% of 275 respondents), while learning in the workplace through observation and feedback is challenging.

**Table 1:** Clinical disciplines of respondents.

	Allied health professional n(%)	Doctor n(%)	Nurse n(%)	Midwife n(%)	Scientific and technical professional n(%)
Number of respondents n=312	59(19)	49(16)	186(59)	15(5)	3(1)

**Table 2:** Survey respondents age distribution and years of experience in healthcare.

Years of experience in healthcare	Age in years							Total years experience
	20–25	26–30	31–35	36–40	41–45	46–50	51+	
0–1 year	63	14	7	3		1	1	89
1–2 years	4	1	1		1			7
2–5 years	11	10	4			1		26
5–10 years	1	9	13	4	2		5	34
>10 years			9	27	28	20	72	156
Total	79	34	34	34	31	22	78	312

The survey data present a picture of the current level of confidence and skill, alongside the realities of accessing and implementing learning into practice. Not surprising is the reporting that comfort and confidence with these skills generally improves with time and experience. Interestingly, there were a small number of experienced older clinicians who rated themselves as less comfortable and confident having this type of conversation effectively. It must be noted that confidence does not always equate with competence.

Two hundred and fifty-five (82%) respondents do not regularly have the opportunity to receive feedback from experienced colleagues on their person-centred communication skills with real people in their care or their whānau. Yet 85% of respondents feel that feedback would be useful to improve their skills.

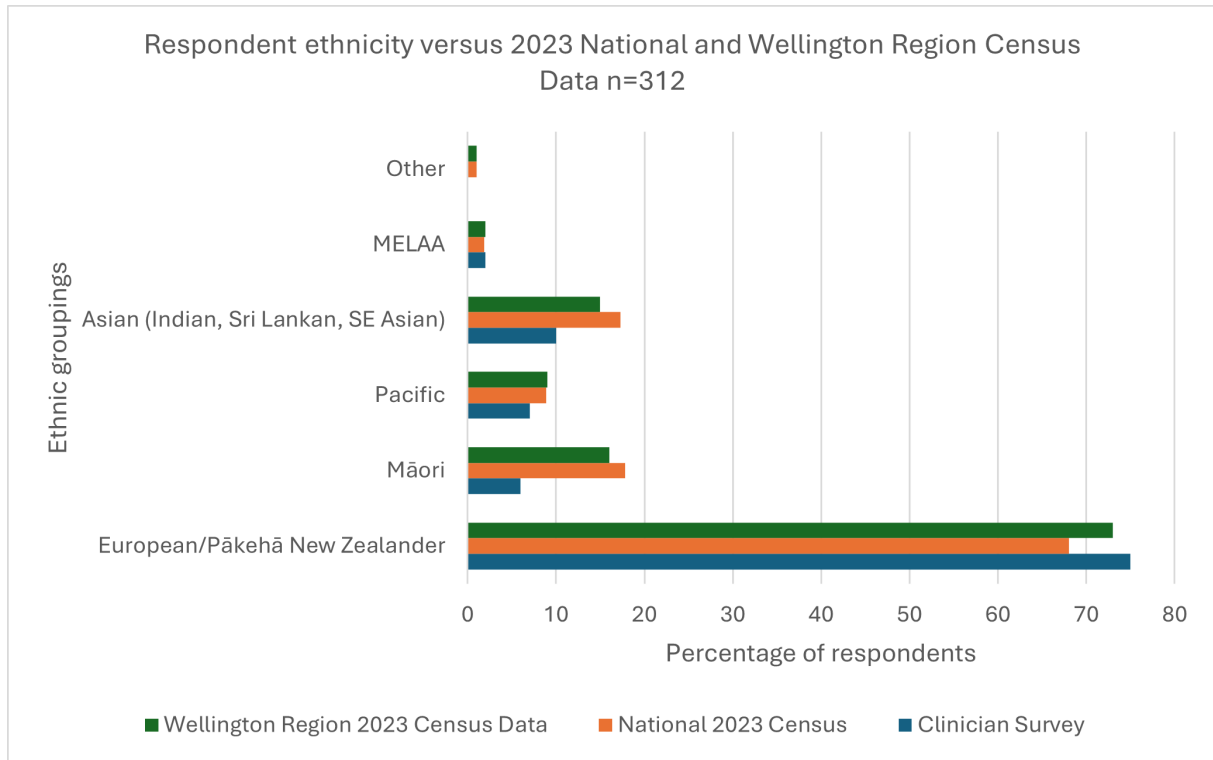
Although 90% of clinicians indicated an openness to using an AI tool that provides feedback on communication skills (Figure 7), concerns were also raised about AI (Table 3). These were categorised

into five general domains.

### Clinician focus group

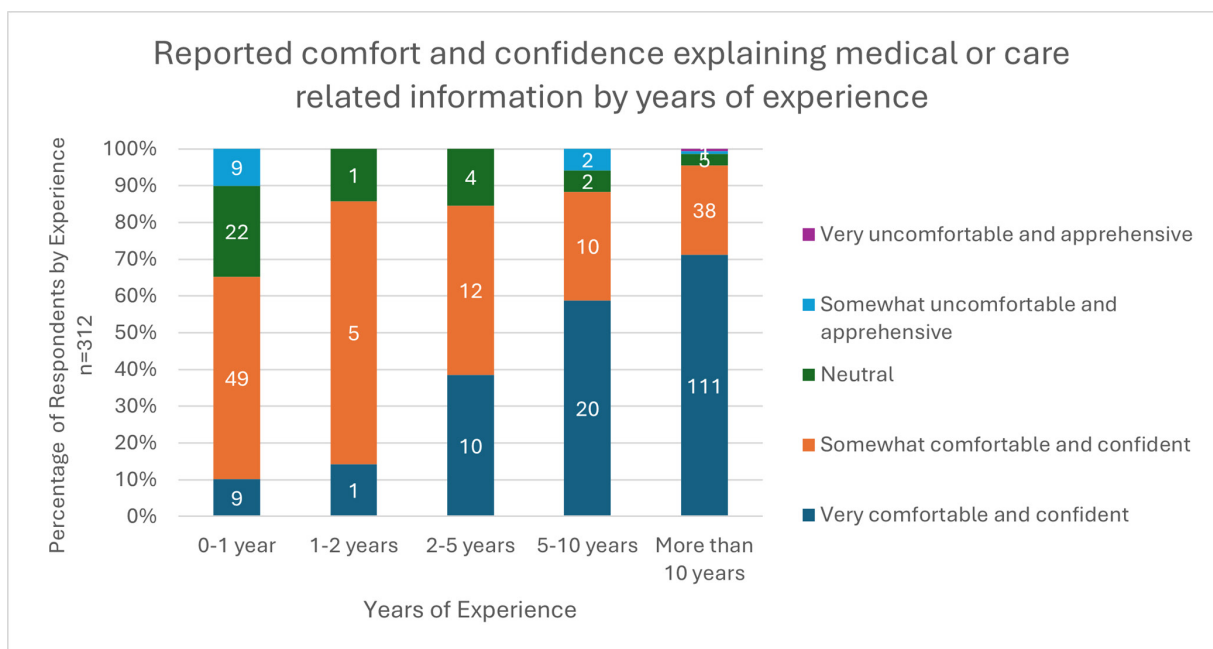
The aim of this focus group was to consider, in more depth, the current approach to PWCC education and the options for a new approach. The group concurred with the clinician survey and consumer focus group conclusions. They expanded on these challenges and stated that clinicians are often unaware of their strengths and weaknesses due to a lack of feedback. This hinders their ability to effectively engage with patients and tailor their communication to individual needs and preferences. Access to education to enable this and culturally safe communication is limited. They raised the fact that the apprenticeship model may not be conducive to open and honest feedback due to concerns about vulnerability and power dynamics. The group described positives and negatives to using AI to provide feedback on communication skills that mirrored the findings

**Figure 1:** Ethnic breakdown of respondents.

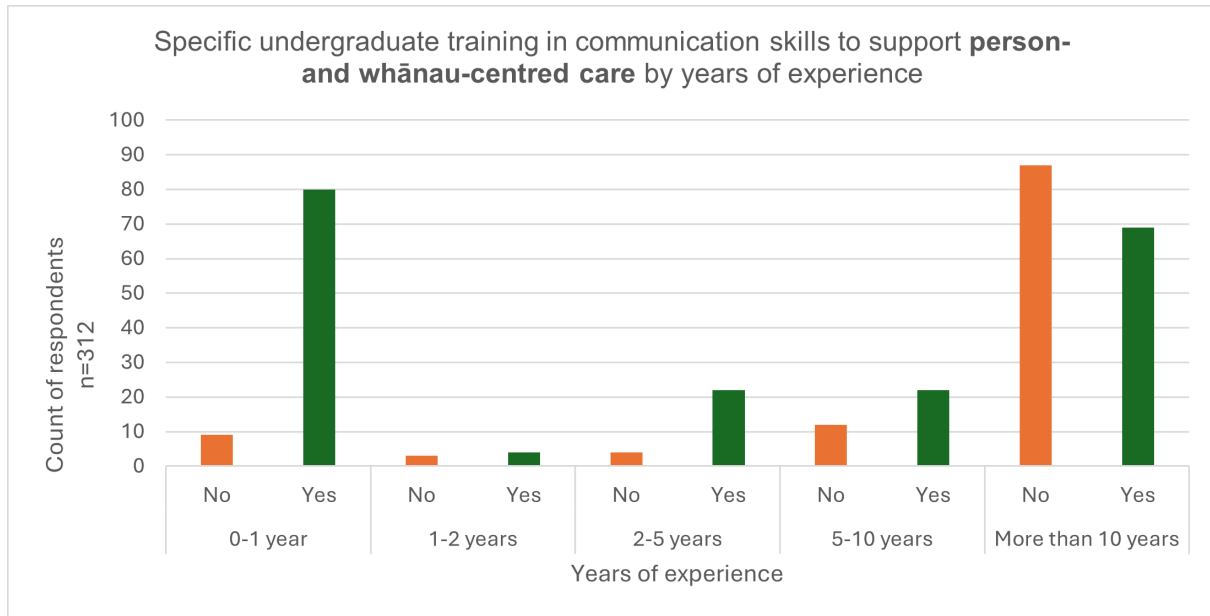


Note: Total response ethnic groups have been used (where everyone is included in every ethnic group they identify with) so percentages add to more than 100%.

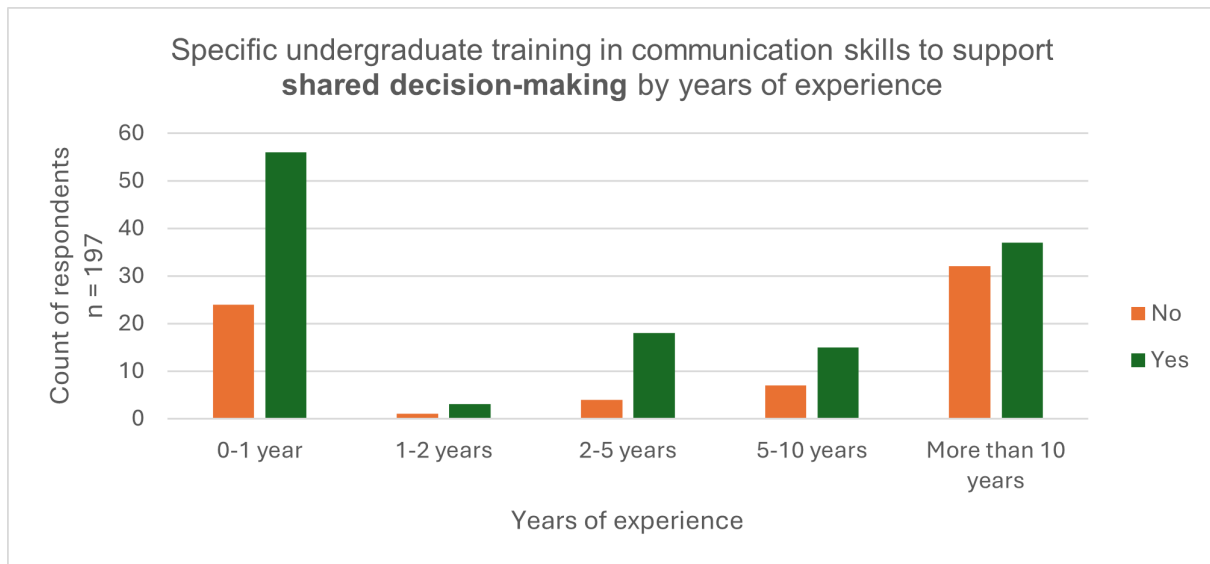
**Figure 2:** Reported current level of comfort and confidence explaining medical or care-related information in a way that is understandable to people and whānau in their care, by years of experience in healthcare.



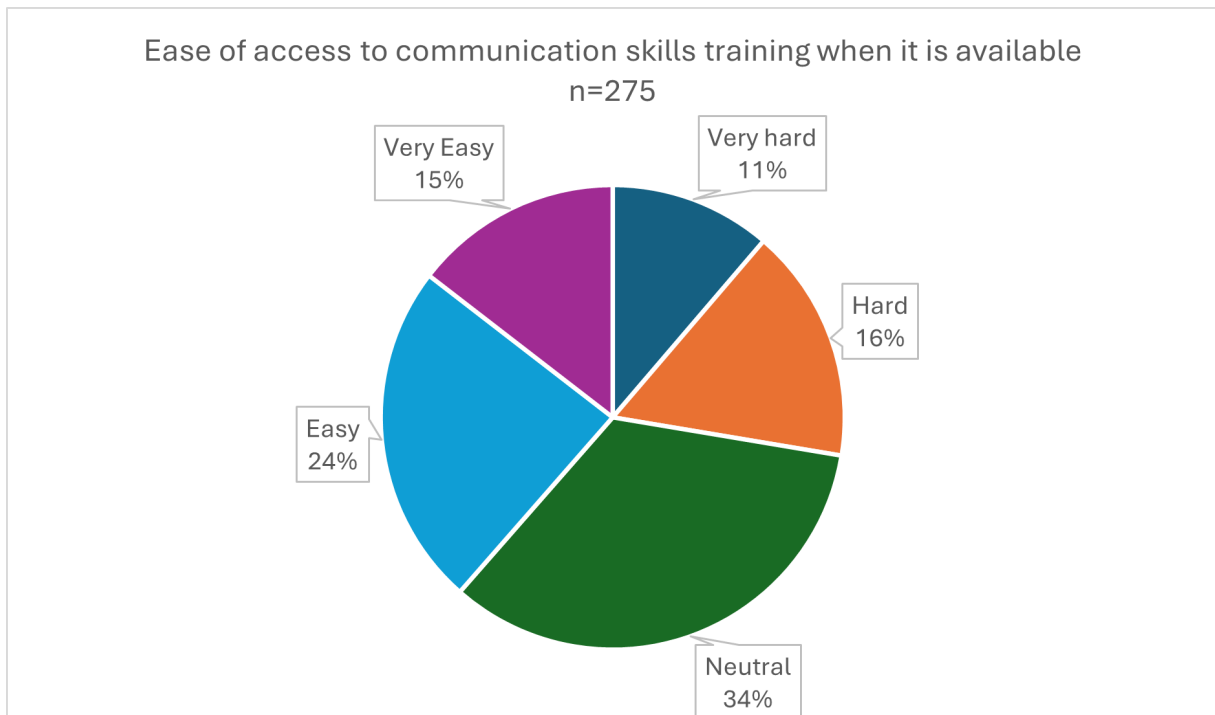
**Figure 3:** Specific undergraduate training in communication skills to support person- and whānau-centred care (PWCC) by years of experience.



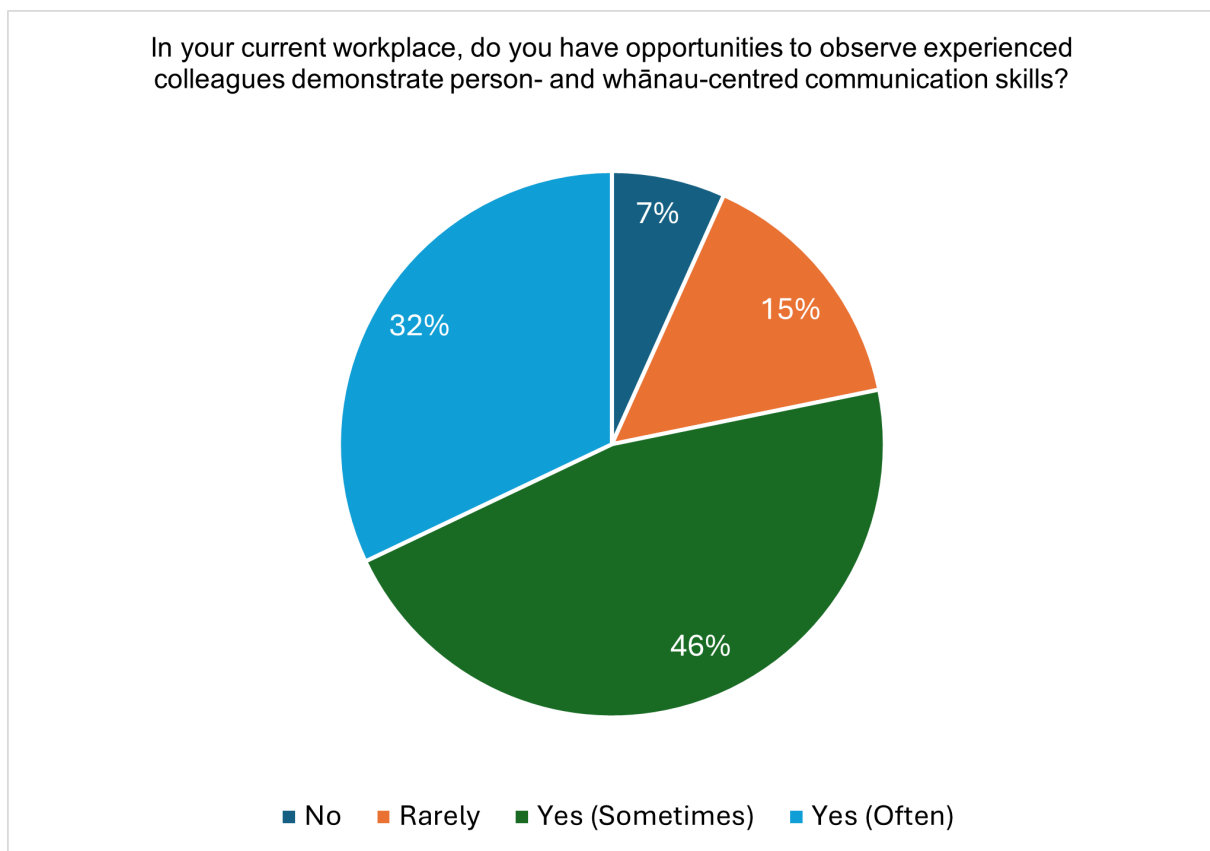
**Figure 4:** Specific undergraduate training in communication skills to support shared decision-making by years of experience.



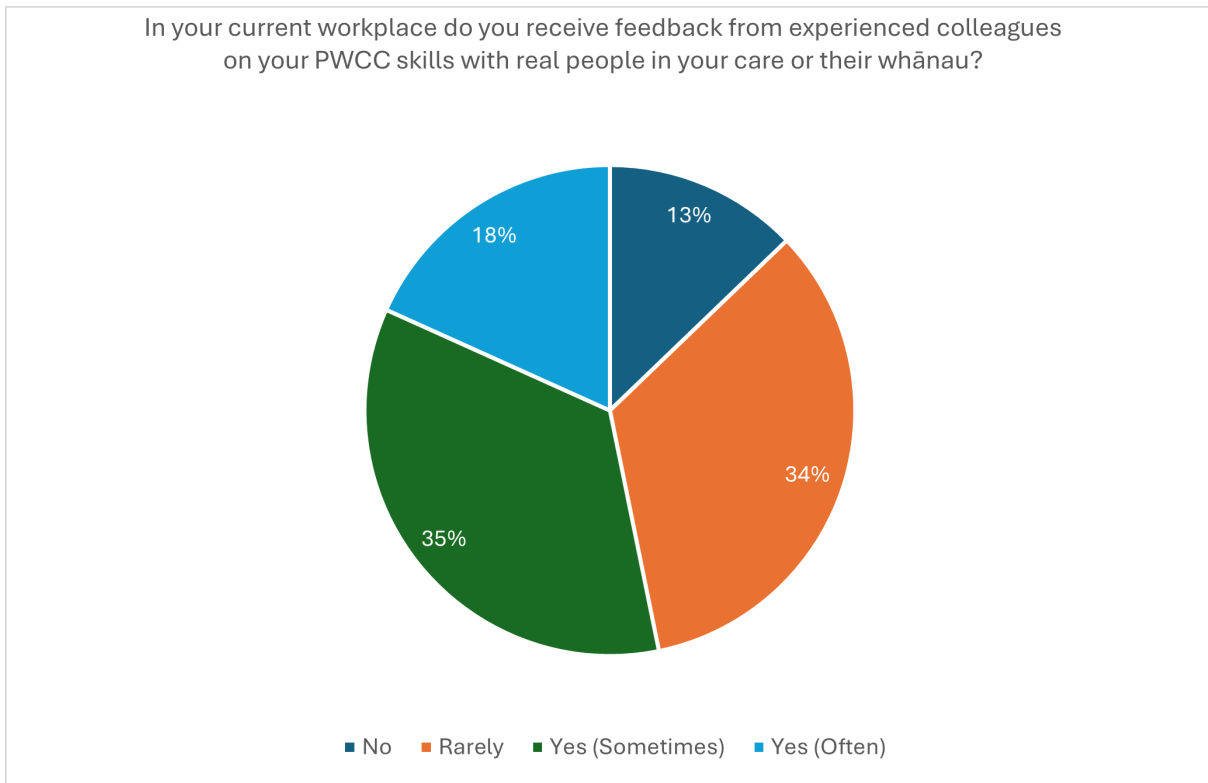
**Figure 5:** Ease of access to communication skills training when it is available.



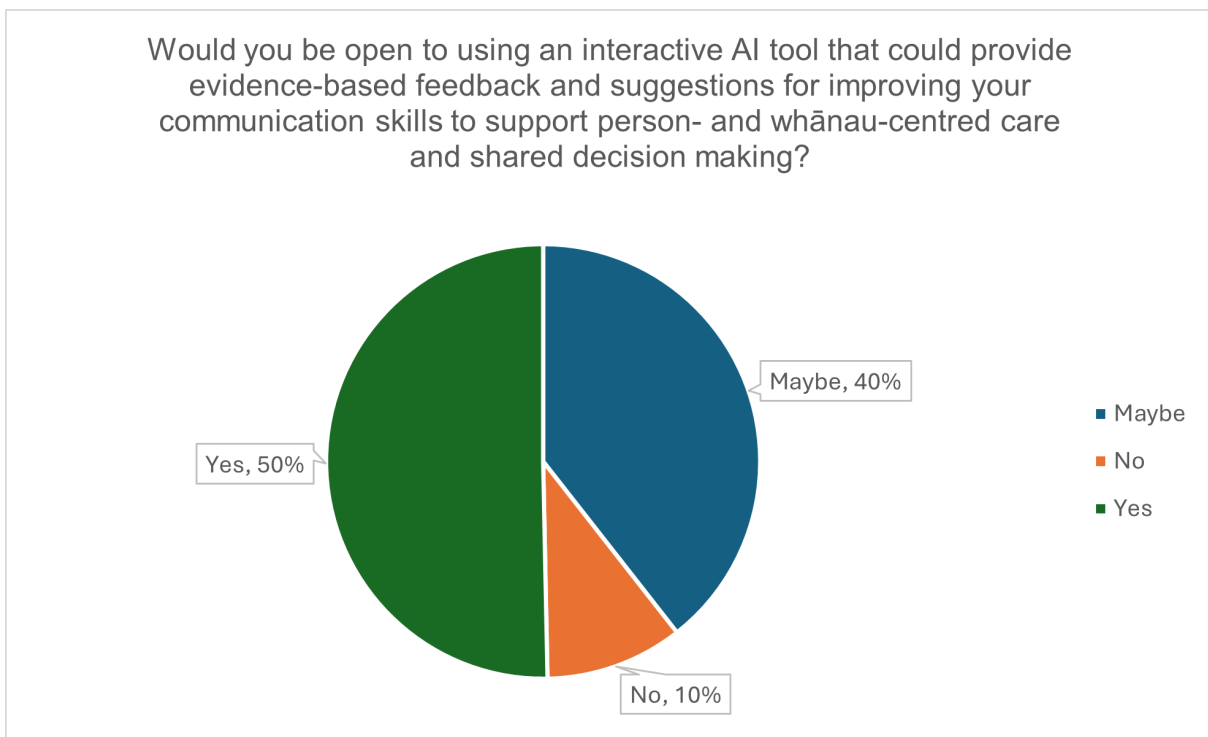
**Figure 6:** Opportunity to observe person- and whānau-centred care communication in the workplace.



**Figure 7:** Receiving feedback on person- and whānau-centred care (PWCC) skills in the workplace.



**Figure 8:** Openness to using an interactive artificial intelligence (AI) tool.



**Table 3:** Survey respondents reported concerns regarding an artificial intelligence (AI) teaching and feedback tool.

Humanity and authenticity	Privacy and data security + IT	Accuracy and reliability	Effectiveness and engagement	Ethical considerations
<ul style="list-style-type: none"> <li>• Lack of human experience—each person and interaction is unique</li> <li>• Artificiality of AI feedback—not personalised</li> <li>• Inability to capture non-verbal cues</li> <li>• Lack of empathy and understanding of human nuances</li> </ul>	<ul style="list-style-type: none"> <li>• Security and privacy of data collection, analysis and usage</li> <li>• Risks to confidentiality</li> <li>• Lack of IT skills to use the tool</li> <li>• IT systems</li> <li>• Being audited—“Big Brother”</li> </ul>	<ul style="list-style-type: none"> <li>• Inaccurate information—validity</li> <li>• Lack of cultural sensitivity</li> <li>• Loss of subtleties and nuances</li> </ul>	<ul style="list-style-type: none"> <li>• Less engaging or impactful</li> <li>• Lack of real-world context—too prescribed</li> <li>• Preference for in-person training</li> <li>• Concerns about effectiveness of AI-based feedback</li> </ul>	<ul style="list-style-type: none"> <li>• Bias</li> <li>• Indigenous perspectives on person-centred care not led by Indigenous</li> <li>• Impact on the planet</li> <li>• Perpetuating and reinforcing stereotypes</li> <li>• Lack of New Zealand centric focus</li> </ul>

in the survey (Figure 7 and Table 3).

## Discussion

Feedback from consumers has provided further validation of the New Zealand patient survey data and the literature in relation to health literacy and PWCC. Despite there being tools available, and recommended approaches to communication in the clinical setting, the lived experience is that these are not regularly being used or used effectively. Health literacy is not being well supported through the routine use of proven tools. Consumer experience reinforces the literature finding that the application of the Hui Process or other culturally safe and person-centred approaches are not yet fully embedded into practice in this setting.

With continuous practice, including the opportunity to make mistakes, have new experiences and critically receive feedback that supports improvement, we are more likely to build skill and confidence. Access to relevant education that supports integration into practice appears to be a barrier to improving PWCC. Current access to communication-focussed education is limited. Only 17% of survey respondents reported attending communication related training in the last 12 months. Senior clinicians are also not receiving regular feedback; yet, in our current apprenticeship approach, senior clinicians are expected to teach the more junior staff.

The current apprenticeship model—learning in

the workplace with feedback—does not appear to be teaching or reinforcing these skills in a meaningful way for all levels. Clinician respondents reinforced the challenge of the apprenticeship model as a way of learning due to concerns about vulnerability.

The differing ethnic profile of our workforce to the New Zealand and CCHV population may be a factor in relation to the consumer experience of culturally safe communication skills. Although the small survey sample may bias the results, it does increase the significance of teaching and enabling implementation of culturally safe practice and communication when considering known health inequities. This may be an area for further exploration and highlights the importance of Indigenous input into this project.

This project has confirmed the need for accessible, effective communication observation and feedback from a person and whānau perspective. AI may have a role in this given the workforce education challenges we have highlighted. Despite the small numbers of survey respondents, the input from consumer and clinician respondents, as well as the clinical project team members' own experiences, support the overarching findings that the traditional approach to teaching these skills is lacking. This includes attending in person training in our currently resource constrained environment and receiving feedback in the workplace (the apprenticeship model).

If our clinicians are not regularly experiencing

learning opportunities in the classroom or in clinical settings and are not receiving feedback in a safe and supportive way, they are not likely to build and use the skills people and whānau say they need. Equally, learning that has occurred has not always translated to skills that effectively support PWCC as suggested by the literature and our consumer group. The potential disconnect between the person and whānau experience and the clinician's perceptions of interactions is a gap, and therefore a learning need we have identified. Addressing these issues requires improved access to communication training that varies with the learners' experience, confidence and skill, alongside regular and trusted feedback mechanisms, and the creation of safe learning environments that prioritise cultural safety and individual needs. The feedback the learners receive needs to be from the person and whānau perspective to bridge this gap.

An AI feedback tool may be a feasible option that can bridge some of the gap identified. Ninety percent of respondents stated they would be open to using an interactive AI tool that could provide evidence-based feedback and suggestions for improving their communication skills to support PWCC and shared decision making. The staff survey and the clinician focus group indicated that the potential for individualised and valid feedback, which is contextualised to the New Zealand context, incorporates cultural safety, and that can be accessed easily at any time, was seen as a potential advantage of this option over the current state.

However, concerns were also raised in relation to validity, data security, potential lack of Indigenous perspectives, perpetuation of stereotypes, environmental impacts, and whether the tool would offer an engaging way of learning. To mitigate this, any tool would need to be co-designed and tested with consumers to ensure that the feedback and coaching given was representative of their perspectives. If designed and built in this way,

with appropriate governance, AI may provide a valid, personalised, and more easily accessed learning opportunity. AI has the potential to provide a foundational learning experience to complement more resource intensive simulation-based education.

### Limitations

The low response rate to the clinician survey may not adequately reflect the entire workforce views. Clinicians who attended the focus group may have been more invested in communication education or be biased for or against AI. They may have stronger opinions than other members of the workforce, although their inputs echoed the survey findings. The consumer group was not representative of the general population.

### Implications

The implications of this work signal the need for effective communication education in healthcare, specifically focussing on PWCC. This must include methodologies that support embedding of learning into practice. Tools will need to be developed to provide accessible and supportive feedback to clinicians. These should be co-designed to ensure they truly reflect consumers perspectives.

### Conclusion

There may be merit in investigating the ability to build an AI feedback tool for more rigorous research and testing of validity, and the impact on learning and skill development. The understanding and transparency of any environmental impacts of such a tool, as well as the importance of Indigenous and broad consumer input into a tool's vector build, design and outputs has been highlighted. Appropriate governance is important. Alongside these key features, the co-design approach needs to remain at the forefront to ensure the PWCC aim is achieved. The project team are investigating options to further this work.

**COMPETING INTERESTS**

Nil.

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## Appendix

### Appendix: Clinician survey.

23/12/2024, 12:27

Person-Centred Care Communication Survey



## Person-Centred Care Communication Survey

Thank you for participating in this short survey to help us understand the training and support available to health professionals in developing communication skills for person-centered care and shared decision making.

Person-centred care and shared decision making can be described as *"a partnership among practitioners, patients, and their families that ensures that decisions respect the persons' wants, needs, and preferences, and that people have the education and support they need to make decisions and participate in their own care"* (Institute of Medicine, 2001).

You are invited to take part in this project. Please read the information below before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request. This survey should take about 6 minutes of your time.

\* Required

### A co-design approach to utilising AI to improve communication skills within healthcare

#### INFORMATION FOR PARTICIPANTS

##### Ko wai ahau / Who am I?

My name is Melita Macdonald and I am a Masters student enrolled in *HLTH551 Professional Project* at Te Herenga Waka—Victoria University of Wellington. This project is work towards the final course of my Masters degree. I am also the Manager of the Simulation Service at Health NZ | Te Whatu Ora Capital, Coast and Hutt Valley.

##### He aha te whāinga mō tēnei rangahau / What is the aim of the project?

The purpose of this survey is to help us understand the training and support available to health professionals in developing communication skills for person-centred care and shared decision making. We aim to co-design a novel teaching and feedback tool for clinicians that supports increased capability in person-centred communication. Through improving the clinician's communication skills, we aim to empower patients and whānau - enabling increased health literacy, shared decision-making and equity of health outcomes. This project assignment has been approved by the Te Herenga Waka—Victoria University of Wellington Human Ethics Committee, Reference number #0000031569.

##### Ka pēhea tō āwhina mai / How can you help?

Your participation will support the project outcomes by providing a contemporary picture of the communication skills learning you engaged in as an undergraduate – and in your current role.

##### Ka ahatia ngā kōrero ka tukuna mai / What will happen to the information you give?

Your survey responses are anonymous. This means that nobody, including me or my supervisor will be aware of your identity. By answering it, you are giving consent for me to use your responses in the report that is written about the project. Your answers will remain completely anonymous and unidentifiable. Once you submit the survey, it will be impossible to retract your answer. Please do not include any personal identifiable information in your responses.

##### He aha ngā hua o te rangahau / What will the project produce?

The information from the project will be used in my final Project Report assignment and possibly academic publications and conferences.

##### Mehemea ngā pātai, he raruraru rānei, me whakapā ki a wai / If you have any questions or problems, who can you contact?

Student: Melita Macdonald  
Email: [Macdonmeli1@myvuw.ac.nz](mailto:Macdonmeli1@myvuw.ac.nz)

Supervisor: Dr Jill Wilkinson Email: [jill.wilkinson@vuw.ac.nz](mailto:jill.wilkinson@vuw.ac.nz)  
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Phone: +64 4 887 3819

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

**Note that all responses are anonymous**

Participating in this survey implies that you are willing for anonymous data collected to be used to inform an improvement project run by the Simulation Service, HNZ | Te Whatu Ora Capital, Coast and Hutt Valley.

**1. What is your primary field of clinical practice at present? \***

- Doctor - PGY1
- Doctor - PGY2
- Doctor - PGY3 or above including Registrars and SMOs
- Registered Nurse - NETP
- Registered Nurse (not NETP) - New Zealand qualified
- Registered Nurse - Internationally qualified
- Registered Nurse - Nurse Practitioner
- Midwife - New Graduate
- Midwife - Not new graduate
- Allied Health Profession
- Scientific or Technical Profession

**2. Please select your age group \***

- 20 - 25 years
- 26 - 30 years
- 31 - 35 years
- 36 - 40 years
- 41 - 45 years
- 46 - 50 years
- 50 years +

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**Appendix (continued): Clinician survey.**

23/12/2024, 12:27

Person-Centred Care Communication Survey

3. Please indicate your ethnicity - choose as many that apply \*

- Māori
- European/Pākehā
- Pacific Peoples
- Asian
- Middle Eastern
- Latin American
- African
- Other

4. Please indicate your gender \*

- Woman
- Man
- Non-binary
- Prefer not to say

5. How many years of experience have you had working in healthcare? \*

- 0-1 year
- 1-2 years
- 2-5 years
- 5-10 years
- More than 10 years

6. How comfortable and confident are you currently with explaining medical or care-related information in a way that is clear and understandable to people in your care and their whānau? \*

- Very comfortable and confident
- Somewhat comfortable and confident
- Neutral
- Somewhat uncomfortable and apprehensive
- Very uncomfortable and apprehensive

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## Undergraduate Communication Skills Training - Person Centred Care

7. Did your undergraduate programme include any specific training in communication skills to support **person-centred care**? \*

Yes

No

8. What type of training did you receive? *Select all that apply* \*

Workshops

Coursework

Online learning

Role play

Simulations

Patient feedback

Other

9. How well did this training prepare you to effectively communicate with people and their whānau to enable person-centred care? \*

Very effective

Somewhat effective

Neutral

Somewhat ineffective

Not effective

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## Undergraduate Communication Skills Training - Shared Decision Making

10. Did your undergraduate programme include any specific training in communication skills to support **shared decision making**? \*

- Yes
- No

11. What type of training did you receive? *Select all that apply* \*

- Workshops
- Coursework
- Online learning
- Role play
- Simulations
- Patient feedback
- Other

12. How well did this training prepare you to effectively communicate with people and their whānau to enable shared decision making? \*

- Very effective
- Somewhat effective
- Neutral
- Somewhat ineffective
- Not effective

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## Your Current Workplace

13. Does your workplace provide opportunities to attend training where you can **practice and receive feedback** on your person-centred communication skills (e.g. lectures, role-playing, simulations)? \*

- Yes (often)
- Yes (sometimes)
- Rarely
- No

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

Your Current Workplace

14. How easy is it to attend communication skills training when it is available? \*



15. Have you attended any communications skills training at work in the last year? \*

Yes

No

16. What communication skills training have you attended at work in the last year? \*

17. How much time did the training take? \*

0-1 hour

1-2 hours

2-3 hours

3-4 hours

4 - 8 hours

1-2 days

Other

18. How useful and applicable was the training to your work? \*



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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## 'On the Job' Learning and Mentoring

19. In your current workplace, do you have opportunities to **observe** experienced colleagues demonstrate person-centered communication skills? \*

- Yes (often)
- Yes (sometimes)
- Rarely
- No

20. In your current workplace, do you have the opportunity to **receive feedback** from experienced colleagues on your person-centred communication skills with real people in your care or their whānau? \*

- Yes (often)
- Yes (sometimes)
- Rarely
- No

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

'On the Job' Learning and Mentoring

21. Is the feedback you receive beneficial to improving your skills? \*

- Yes
- Somewhat
- No

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

'On the Job' Learning and Mentoring

22. Would feedback be useful to help you improve your skills? \*

- Yes
- Perhaps - please explain why below
- No - please explain why below

23. Please explain why you feel feedback may not be useful to help you improve your skills

**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## AI-Based Learning

24. Would you be open to using an interactive AI tool that could provide evidence-based feedback and suggestions for improving your communication skills to support person-centred care and shared decision making? \*

- Yes
- Maybe
- No

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## AI-Based Learning

25. What features would you find most helpful in an interactive AI tool for communication skills development and feedback? (Select all that apply) \*

- Identifying my areas of strength and areas for improvement based on simulated interactions with the tool/avatar
- Offering feedback on the clarity and understandability of language I use
- Offering feedback on cultural appropriateness of the communication and approach I use
- Providing examples of clear and person-centered communication
- Providing examples of opportunities for shared decision-making
- Other

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

## AI-Based Learning

26. What potential benefits do you think there might be to using evidenced-based AI tools for communication skills development? \*

- Ease of access to training
- Evidenced based - reliability and validity
- Ability to practice more often
- Tailored feedback
- No risk to you or the patient and whānau when practicing
- Less threatening
- Having a transcript or summary of the interaction of the AI tool and key learning points
- Other

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**Appendix (continued):** Clinician survey.

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Person-Centred Care Communication Survey

AI-Based Learning

27. Please describe any concerns you may have about using AI tools for communication skills development.

28. Thank you for your participation in this survey! Please add any other thoughts or comments below.

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