

Residency Training: Teaching communication

Residency is not too late

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Resident Dr. A is called to speak with the family of a patient in the neurointensive care unit who has malignant left middle cerebral artery syndrome and is close to brain death. Resident Dr. A has many competing obligations that day, but realizes how important the discussion will be. As he stands outside the family conference room where anxious loved ones wait, he contemplates what he is going to say and how. Having done this before, he feels confident that he can do it well. What he does not realize is that on the other side of the door are 20 frightened family members who speak a different language, have many different beliefs, and have no idea that their family member is dying. Resident Dr. A's confidence is based on sufficient knowledge of the patient's illness and prognosis, but despite decades of formal education, he was never taught how to effectively communicate with patients and their families in this situation.

WHY TEACHING COMMUNICATION IS IMPORTANT

There is no question that advances in medical knowledge have forced medical schools to find creative ways to efficiently educate their future physicians. What about teaching communication? This is not a new problem. Time dedicated to teaching communication is sparse. The exponential trajectory of information required to be a physician is daunting, and conveying that information to patients imposes yet another challenge. The ability to communicate with patients, families, and other medical staff is essential in a complex medical society, and should require attention and instruction. Not only do patients deserve such skills in their physicians, but residents actually want these skills and desire to participate in educational experiences that teach how to communicate effectively.¹

It is known that a connection exists between healing and human relationships.² People who enter the study of medicine often have preexisting qualities of humanism and intelligence. However, these qualities do not imply that these people have sufficient understanding of how to engage the complicated and sensitive realm of physician-patient communication. Resident physicians are interested in their patients, and may care about them as human beings, but may not be able to utilize

their compassion in a clinical setting that would produce the best outcome for the patient. Communication is the exchange of information. In a physician-patient relationship, the physician will often need to possess a verbal and nonverbal construct that will allow sharing of information that will focus not just on the disease and treatment, but also on the patient and the patient's reactions and experience of illness. With formal guidance, can residents learn how to obtain these skills? Is residency too late?

Data suggest that residents can be taught these skills and that patients want their physicians to have these skills.³ It is not surprising that patients want their doctors to listen and explain things well. Who could blame them? Research has shown that effective communication influences the rate of patient recovery, effective symptom control, adherence to treatment plans, psychological stability, and satisfaction with care.⁴ Effective communication not only benefits the patient, but also the well-being of the physician. Residents who report insufficient communication skills training have a higher risk of burnout, and furthermore, physicians who endorse satisfactory communication skills report increased job fulfillment.⁵

Both patients and residents advocate for improved communication education, but is not experience alone sufficient? This may not be true, as previous reports have suggested that time and experience alone may not produce adequate improvements in physician communication.¹ The Accreditation Council for Graduate Medical Education requires competency of communication and professionalism. Unfortunately, these competencies are often learned informally, without formal instruction. In order to comply with the Accreditation Council for Graduate Medical Education, communication skill development will require practice and instruction, not just educational interventions that increase knowledge. Studies suggest that residents can learn these skills and maintain them over time.⁶ Residency may not be too late.

PREVIOUS INTERVENTIONS There are a variety of studies in the literature that focus on teaching communication interventions. Many of those reports

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address resident acceptance of the intervention, but also attempt to measure objective outcomes. The challenge for those programs is not just to provide information to the residents about effective communication, but to nurture the development of skills and behaviors that lead to positive clinical encounters and outcomes.

Previous studies on teaching communication often utilized intervention techniques such as formal coursework, skills workshops, role-playing, and patient simulation. For example, Langewitz et al.⁷ randomized internal medicine residents to a patient-centered communication skills intervention consisting of specific communication skills education and interviews with simulated patients. They had mixed results, but overall they demonstrated that communication skills can be taught. Residents in both the control and intervention group showed improvement in communication skills related to medical information identification and discussion of treatment options. However, the intervention residents were better at actively listening to their patients, inviting the patient to share decisions, and encouraging patient participation in health care negotiation. Roter et al.⁸ showed that a 1-month course for interns dedicated to interviewing skills and the psychosocial history led to fewer leading questions and more open questions when interviewing a simulated patient. Smith et al.⁹ showed an increase in communication knowledge for residents randomized to a communication skills intervention, but also an increased self-reported confidence among the residents. In another study, two-thirds of junior house officers who attended a 1-week graduate communication skills course found the experience helpful and felt that further training would be beneficial.⁴ Finally, a pilot study for neurology residents used a series of 6 case-based communication skill workshops (e.g., breaking bad news, discussing do-not-resuscitate orders, communicating with “difficult” patients, disclosing medical errors, obtaining informed consent, and end-of-life decisions), and found that the experience was viewed favorably by the participating residents and felt to be relevant to their practice.¹

Providing lectures on communication skills, interviewing simulated patients, and role-playing seem to be effective strategies to teach communication. It is not clear how well these interventions work when residents and physicians interact with real patients. In an effort to address this question, researchers using the Palliative Care Clinical Evaluation Exercise (CEX) with actual seriously ill patients in real clinical settings showed that the intervention was positively valued by residents.¹⁰ The Palliative Care CEX intervention was modeled after the CEX and based on faculty observation of trainees’ interactions with patients, focused primarily on giving bad news and “code-status” discussions. Further research is needed to show whether

these interventions can improve the patient experience and health outcomes.

CONCLUSION Evidence suggests that residents want and need to learn how to communicate, that patients desire that their physicians can communicate, and that communication interventions are often viewed favorably and are effective. Teaching communication can be done. Residency is not too late. In fact, it is probably never too late. If it is not taught in medical school or residency, then it should be learned during fellowship or as staff. Teaching communication should start in medical school, but should not stop there. The patient responsibilities and experiences are vastly different in residency compared with medical school, and often lead to unexpected encounters that require effective and compassionate communication between physician and patient. A resident alone in the hospital may be able to successfully diagnose and treat a patient, but they may not be able to develop an optimal relationship with the patient because of ineffective communication skills.

Resident Dr. A entered the room and updated the family. He addressed their concerns and answered questions to the best of his ability. They thanked him for his care. Later that morning, the hospital chaplain asked Resident Dr. A questions about the patient such as goals of care, code status, and end-of-life decisions. Resident Dr. A was confused. He knew what the answers should be, and even discussed these topics with the family, but did not know how to adequately convey his message to the family. He had failed to reach an understanding. Unfortunately, it is not possible to anticipate and practice every scenario a physician will encounter, but it is possible to prepare residents for these experiences by teaching them how to communicate.

Being a physician is a privilege. We have a responsibility to our patients and the community. Further education research on teaching communication is necessary, and should be a goal for all neurology training departments. Very little information is known about teaching neurology residents how to communicate. Medical educators need to develop educational programs that aim to teach residents how to communicate (i.e., giving bad news, code status, goals of care, informed consent, and end-of-life issues), improve humanistic qualities, and demonstrate methods of managing stress and crisis. The ideal architecture of these programs is not known, but efforts to create them should include standard ways to quantitatively, and perhaps qualitatively, measure outcomes such as patient satisfaction, health outcomes, and physician satisfaction. This can be done, but it will require dedicated educators, supportive institutions, collaboration, motivated learners, and understanding patients. Residents will learn how to communicate.

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