Right Brain: Breaking bad news

Communication education for neurology trainees

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RECENT TRAINEE PERSPECTIVES Monica
E. Lemmon, MD, neonatal neurointensivist:

"They couldn't give us any indication on what may or may not be wrong. It was just day by day; we're just going to have to see how she does for the next 6 months. And I don't think you understand what that means to a parent. It can really mess up the mom when she doesn't know how her kid's going to be."

—Mother of infant with neonatal encephalopathy¹

The stories are frighteningly similar—a normal pregnancy taken to term, a perinatal crisis, followed by an emergent cesarean section and infant transport to a tertiary hospital, where therapeutic hypothermia is initiated. I usually meet the family shortly after arrival, at which point I am charged with helping them understand the next steps. Like so many others, I frequently find myself in complex discussions with families about prognostic uncertainty, advanced care planning, and lifelong disability. Navigating these conversations poorly can have devastating consequences. In many conditions I treat, whether or not a child dies does not rest on my ability to learn, understand, or recommend treatment, but instead on the outcome of conversations in which a family considers whether to withdraw or withhold life-sustaining treatment. As a neonatal neurointensivist, these high-stakes conversations are the most critical interventions I perform.

Despite the frequency and complexity of difficult conversations in my practice, I had little directed instruction in communication skills during my training. I recall lectures on "giving bad news" in the preclinical years of medical school and a couple of standardized patient experiences; however, in the absence of patient context, I did not appreciate their value. In residency, I watched master communicators in action; however, I never used these opportunities to critically evaluate communication strategies. I led family meetings; however, I was rarely observed and was never given directed feedback on my ability to communicate with families. These were missed opportunities for me to gain new skills, identify bad habits, and engage in the literature around

communication. As neurologists join the science of understanding and improving communication with patients and families,² we must consider how to intentionally incorporate evidence-based communication skills training into our education models.

Roy E. Strowd, MD, neuro-oncology:

"My mother died yesterday. My head is swirling. It was never a mystery that this day would come. She had a terminal brain cancer and we all knew from the beginning that this wouldn't be good. I was ready for this possibility; ready to lose her. But I wasn't at all prepared for not knowing when this day would come; for the guessing."

—Daughter of a patient with a malignant brain tumor (Strowd)

Like so many other trainees, I worked hard throughout medical school, residency, and fellowship training in neuro-oncology to master the science of medicine, neurology, and patient communication. I, too, recall observing lectures and completing standardized patient examinations; I was assessed on eye contact and graded on the ability to recognize and respond to empathetic opportunities. Yet, when clinical clerkships offered the occasion to debrief with an expert educator after an instructive end-of-life discussion or when residency training provided occasion to be observed in the act, chances were missed, assessment was informal, and feedback was rare.

Communication is a fundamental skill that while exemplified in these difficult conversations underlies nearly every day-to-day action that I have with my patients. Some conversations are clearly never easy—"You have brain cancer." I have learned the evidence-based delivery: I find a comfortable environment, assess the patient's understanding, determine how much information he or she wants delivered, give the truth, address the emotion, and summarize. For me, it was not until my neuro-oncology fellowship that I learned of the ABCDEs (*advance preparation, building a therapeutic relationship, communicating well, dealing with patient and family reactions, encouraging/validating emotions*) of breaking bad news,³ the

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Figure Proposed stepwise communication skills education

6-step SPIKES approach (setting, perception, invitation or information, knowledge, empathy, summarize or strategize),⁴ or saying AMEN to (affirm, meet, educate, no matter what) bridge the gap in a challenging conversation.⁵ Like other trainees, formal education was lacking and it was not until well after residency training, driven by the need to independently lead such discussions, that I was exposed to these evidence-based approaches to difficult conversations.

Like so many other neurologic conditions, the difficult part of these conversations does not end with the bad news. The patient, family, and I already know that this condition is terminal and we recognize that treatment leaves too much to be desired. Faced with death, patients are resilient. They know that now is the time to prepare and that the course will likely be difficult. Together we overcome these concerns with honesty, but we are both consumed by uncertainty.

Even for this terminal condition where recurrence is universal and the outcome is unwavering, the difficulty of conveying or hearing this uncertainty can be overwhelming. When will disability ensue or a job be lost? When will progression come: this scan, next scan, or not for years? Will this chemotherapy treatment be the last? Will this day be the end? It is suffocating, clogging the room and clouding the mind; it turns a difficult conversation into stifling discomfort; a data-driven approach into an uncomfortable silence, which not even AMEN can address. A devastating disease, this incurable cancer has been life-changing ... for me.

COMMUNICATION EDUCATION IN NEUROLOGY: A CALL TO ACTION Neurologists care for patients with life-limiting, life-threatening, and life-altering diagnoses. Doing so well demands a unique skill set in communication that ranges from delivering the diagnosis to sensitive conversations about new disability, end-of-life care, advanced care planning,

or brain death; many of these conversations occur within the context of substantial prognostic uncertainty. Communication interventions have improved patient and family outcomes in a variety of conditions. Recognizing the importance of effective communication to high-quality patient care, the Institute of Medicine recently called for the incorporation of communication quality metrics into licensing and continuing education standards.⁶

Despite the frequency and complexity of difficult conversations in neurology, training and evaluation in communication skills is primarily informal. Professional organizations, including the Accreditation Council for Graduate Medical Education (ACGME), recognize that communication and interpersonal skills are a core competency in medical training and practice.⁷ Some medical schools have embraced these competencies in their preclinical and clinical curricula. Communication skills are an integral component of the neurology residency milestones, which are used to measure the educational efficacy of neurology training programs.⁸ Patient assessments and 360-degree evaluations have been incorporated to provide documentation support of communication skills training assessment in neurology trainees.⁷ Gaps in current training and opportunities for growth have been recently identified in neurology trainees' understanding of communication and palliative care principles.^{2,9}

For medical students, the neurology clerkship represents a potential opportunity for clinical communication skills training. The Undergraduate Education Subcommittee of the American Academy of Neurology recognized this and recently outlined a longitudinal model for the incorporation of the ACGME core competencies into a neuroscience curriculum.¹⁰ This group of educators emphasized the importance of developing each competency throughout the preclinical and clinical years. For the communication

and interpersonal skills competency, they outline a stepwise process for introducing the student to clinical communication, with a progression from standardized patients and role-playing exercises to supervised patient discussions of increasing level of difficulty (figure).

For neurology residents, communication skills are a core competency of training⁸; however, formal curricula in communication skills have not been widely described. Discussing neurologic prognosis in a way that can help families and patients make decisions about their health may be a particularly important area to target.¹¹ For trainees, estimating prognosis in the face of limited experience risks poorly informed and vague communication to patients and families. Offering transparent and clear communication with families about prognosis, even in the face of prognostic uncertainty, is challenging and necessary. As we consider how to target communication skills training in neurology, ensuring that trainees are well-versed in established frameworks of how to estimate and discuss prognosis with neurology patients is critical. Communication skills curricula and training have been described in a number of other fields, including internal medicine and pediatrics. In these fields and others, curricula have shown that communication skills can be taught and measured. The current neurology milestones offer an important guide. Next steps include identifying specific communication skills that should be acquired during training, defining appropriate metrics of success, and standardizing curricula across programs. Currently available training programs (e.g., vitaltalk.org) offer an evidence-based template for curriculum development.¹²

Effective communication is central to the care of patients with neurologic disease. Clinical neurology offers unique, complex opportunities to study and teach communication skills. As the science around communication and communication skills training evolves, neurologists must join the daunting effort to define, measure, and teach these skills to the next generation of trainees.

AUTHOR CONTRIBUTIONS

Dr. Lemmon was involved in manuscript conception and design, drafted and critically revised the manuscript, and approved the final manuscript as written. Dr. Strowd was involved in manuscript conception and design, drafted and critically revised the manuscript, and approved the final manuscript as written.

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