

Moving Toward Entrustment of Difficult Conversations

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Despite growing recognition of the importance of communication and its impact on outcomes,¹⁻⁵ we are still learning what is essential to teach in each conversation, how to teach it, and how to institute a competency-based education and assessment system for communication skills.⁶ In this issue of the *Journal of Graduate Medical Education*, 2 articles about teaching medical error disclosure provide important insights into how this particular conversation is learned. These articles also highlight 2 broader needs for moving the field of communication skills training incrementally closer to a state that ensures uniform, reliable skill acquisition and the eventual entrustment of the multitude of important conversations physicians are expected to perform.

Gardner and colleagues⁷ examine the skills of residents in multiple specialties in disclosing medical errors using assessment by standardized patients and debriefing, without any associated uniform presimulation instruction. This offers a snapshot of the outcomes achieved by typical training practices. The findings showed that residents near the end of their first year display great variability in error disclosure skills. Many residents missed key steps, such as taking responsibility and describing personal actions for preventing future errors. In other words, current training methods are insufficient. Despite limitations, including sample size, single institution bias, lack of interrater reliability on the scale, and lack of patient-level outcomes, the study offers a standardized method of assessment of a key communication task that was feasible and well received.

Where Gardner et al focused on evaluation in the simulation lab, Singh et al⁸ surveyed residents across specialties about preferences for faculty involvement as they practice and use error disclosure skills with patients. Residents indicated that, even with training in and experience with error disclosure, they want faculty to help in preparing for and conducting the conversation, and they want feedback after the conversation. Interestingly, 83% of residents also wanted personal support (ie, help coping) from faculty regarding the conversation. While limited by

the fact that these are resident self-reports from a single study, the findings provide some of the first clear guidance about what residents want when translating communication skills to the bedside.

While the 2 studies focus on disclosure of medical errors, we see similar patterns in other conversations, like sharing bad news and discussing goals of care. Residents are actively having these discussions, yet often lack skills, despite training, and they express a desire for more help in acquiring the skills and bringing them to the bedside.

The articles in this issue point toward 2 important needs to help the education community move forward. First, it is time to move from time-based learning modalities to competency-based models that provide improved foundational skill development and consistent, standardized learning outcomes. Additionally, they demonstrate that we need to develop methods to support learners as they bring skills from their training environments to the bedside. Fortunately, there are some approaches within the communication skills training literature that could begin to meet the needs raised by these studies.

Mastery learning is an education modality that ensures little to no variation in education outcomes by engaging learners in deliberate practice until they achieve a minimum passing standard.⁹ Mastery learning has been used extensively in procedural skills training and has been shown to have many downstream effects, including improved patient care practices, patient outcomes, and cost savings.^{10,11} Recently, medical educators have begun applying these methods to communication skills training, with promising results.^{12,13} Gardner and colleagues made important strides in their study by developing a checklist of key skills and a method of assessment. Mastery learning offers an opportunity to build on this foundation. By using their evaluation tool as a preworkshop assessment, learners could receive feedback to inform further deliberate practice in the simulation lab to acquire key skills. A minimum passing standard could be determined,¹⁴ and learners could practice until the standard is reached. Using tools like a checklist and mastery learning, communication skills training could move to a model where

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outcomes are uniform and only the time of training varies.

Singh and colleagues add to this by reinforcing the need to support learners as they move from their simulation and didactic experiences to the bedside. One potential faculty development model for bringing communication skills to the bedside involves teachers and learners working together prior to a difficult conversation to determine what is challenging for learners and what skills they may use to help navigate that challenge.¹⁵ The teacher and the learner also negotiate how the faculty member can intervene in a helpful and supportive manner. If needed, specific roles in the conversation can be assigned, allowing the faculty member and the learner to each complete an assigned part. This framework then provides a clear structure to guide debriefing after the encounter: discuss what went well, brainstorm a learning opportunity, and identify a take-home point the learner can apply to future situations. We pair this model of bedside communication skills teaching with extensive training in the simulation lab for our palliative care fellows and find the 2 approaches work well together.

Singh et al also found that residents often looked to their attending physicians not only for guidance in communication skills, but also for personal support surrounding these conversations. This issue raises the question of whether improved training modalities would not only help patient-level outcomes, but also might help ease the psychologic burden on clinicians after they disclose an error or have another challenging conversation. Further research is needed to determine if skills training alone might help meet these supportive needs, or whether further debriefing methods would be necessary to support learners in these challenging conversations.

In summary, these articles make it increasingly clear that old communication skills training models consisting of didactics and unstructured role modeling in clinical practice are insufficient. Instead, we need a 2-layered approach of robust, competency-based training in the simulation lab followed by structured mentoring to bring skills to the bedside. To make this a reality, much work needs to be done. We need more research to define the important skills and steps in each conversation. Checklists need to be created and validity evidence gathered, interrater reliability needs to be established, and each needs a minimum passing standard set by experts in the field. We need research comparing different models of deliberate practice to make it as effective and efficient as possible, and we need studies comparing methods for bringing the skills to the bedside. Faculty will need to be trained in the most successful models, and methods for the final

determination of entrustment will need to be developed. Finally, we need further research linking training to patient outcomes to justify the investments in this training. While this may seem daunting, foundations are being laid, tools are being published, and we are getting closer to being better able to train our learners in one of the most important things we do—talk to our patients and their families.

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