Parents as Teachers: Teaching Pediatrics Residents the Art of Engaging in Difficult Conversations

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ABSTRACT

Background Physicians often lack the skills and confidence needed to have difficult conversations with patients and their families. Patients and families who have experienced these conversations can provide valuable insight for resident physicians.

Objective We developed a communication skills workshop for pediatrics residents using parents and a team of social workers, nurses, chaplains, and physician facilitators in role-playing exercises.

Methods From 2007 to 2016, half-day "difficult conversation" workshops were held annually for postgraduate year 1 (PGY-1) and PGY-2 residents that included an interprofessional team and parents of children with life-threatening diagnoses. Questionnaires assessed residents' prior training, effectiveness of the sessions, and narrative feedback on the impact of this approach. Parents and team members were surveyed on the effectiveness of the training and the value of parent involvement.

Results Median self-reported confidence levels for incoming PGY-1 residents following the workshop rose from 2 to 4 on a 5-point Likert scale (99% response rate [128 of 129 surveyed], $P < .001$). The majority of PGY-2 residents (91%, 115 of 126) reported the workshop increased their confidence in engaging in difficult conversations (91% response rate [126 of 139]). Parents and clinical care team members agreed that parents would likely be preferable to standardized actors for these types of role-playing exercises (84% response rate [37 of 44]).

Conclusions Involving patients' parents and an interprofessional team in role-playing scenarios was a well-received method for teaching residents how to engage in difficult conversations with patients and families, and improved their self-reported confidence when having these conversations.

Introduction

Emotionally charged medical conversations are challenging for physicians and family members. Proficient communication forms the basis of a supportive and trusting relationship among physicians, patients, and families. It positively influences patient and caregiver trust in recommendations for care, and it may improve patient outcomes.[1–3] Physicians often feel anxiety over how to present difficult news to patients and families without eliminating hope or increasing distress.[4]

Current training models for conducting difficult conversations with patients and families may not be adequately building physician confidence and competence.[5,6] Programs that incorporate training typically use actors to portray patients and family members in role-playing exercises,[4,7–9] to teach how to respond appropriately to emotions, to provide realistic hope, and to understand family expectations.[5,8,10,11]

From the patient perspective, good communication is based on the emotional aspects of an interaction with a physician, not just whether specific actions are adhered to, such as avoiding jargon.[7,8,12–14]

We created a simulation in which residents interact with an interprofessional team and the parents of children with life-threatening diagnoses to learn the skills needed to navigate difficult conversations.

Methods

In 2007, physician faculty at Dell Children's Medical Center, now affiliated with Dell Medical School at the University of Texas at Austin, developed half-day workshops for incoming interns and rising second-year residents to help them develop empathetic listening and other skills to assist in addressing difficult conversations encountered in pediatric practice. The workshops occurred during intern and resident orientation in vacant patient rooms or conference rooms that were rearranged to resemble family consultation rooms.

Nurses, social workers, and chaplains were recruited annually as volunteers to encourage residents to consult experienced professionals for support and guidance. In 2008, we introduced patients' parents into the workshop. Initially, the physicians and social workers reached out to prospective parent volunteers. More recently, we have used a parent liaison to

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avoid the unintentional coercion that can stem from a parent's sense of obligation to a health care provider. Small group sessions were facilitated by volunteer physician faculty from the departments of pediatric palliative medicine, intensive care, and ambulatory pediatrics.

To prepare for the sessions, including the selection of the clinical care team and parents, physicians and parent liaisons met approximately 5 times per year. Annual faculty and clerical time to schedule and plan the workshop was approximately 20 and 2 hours per year, respectively. Prior to the workshop, physicians contacted prospective parents to discuss the program's aims, structure, and potential for causing stress. Copies of the role-playing scenarios were provided in advance, and parents were encouraged to excuse themselves from any scenarios they felt would be too emotionally challenging.

Postgraduate year 1 (PGY-1) sessions began with a lecture that explained the process of having difficult conversations and addressed special circumstances such as the role of surrogate decision makers, medical errors, and the death of a child. Sessions for PGY-2 residents began with a video to facilitate discussion on the importance of good communication, intentional listening, and empathy.

Participants were divided into small groups of 6 to 7 residents, 1 physician faculty facilitator, 1 nurse, 1 social worker or chaplain, and 1 to 2 parent volunteers.

Residents from prior years provided clinical scenarios that reflected topics encountered in pediatric medicine, and the workshop's physician faculty edited them to meet the aims of the workshop, focusing on the types of conversations they are likely to encounter (TABLE). During the small group sessions, each resident assumed the role of the physician in one of the scenarios; parents and clinical care team members assumed their respective positions. Following each scenario, the faculty physician facilitator led a debriefing to elicit feedback and insights from the group. Each scenario and debrief was allotted approximately 20 minutes. At the end of the breakout sessions, participants reassembled, shared insights from their small groups, and discussed resources available in the hospital to continue to develop their communication skills.

To minimize parental stress, hospital chaplains held a debriefing luncheon to give parent volunteers an opportunity to talk about emotions that arose from the role-playing exercises and to provide a network of supportive peers.

This study was reviewed and approved by the Seton Institutional Review Board at Dell Children's Medical Center.

What was known and gap
Many residents lack the skills needed to have difficult conversations with patients and their families, but patients and caregivers who have experienced these conversations can offer valuable insight to residents.

What is new
A communication skills workshop for pediatrics residents that uses parents of children with life-threatening diagnoses and an interprofessional team to engage in role-playing exercises.

Limitations
Single site, single specialty study limits generalizability; questionnaires lack validity evidence.

Bottom line
An educational model that uses patients' parents and an interprofessional team in role-playing scenarios instead of standardized actors improved residents' immediate self-reported confidence in having difficult conversations with patients and their families.

TABLE
Case Scenario Topics for Trainees in Difficult Conversations Workshop (2010–2016)[a]

Interns	Residents
▪ Disclosing a new life-threatening/altering diagnosis ▪ Disclosing a medical error ▪ Discussing with parents the need to proceed with a child abuse evaluation ▪ Informing parents of the need to escalate care (transferring a patient to the intensive care unit) ▪ Reaching consensus on a child's plan of care after parents receive differing opinions from consulting medical services ▪ Delivering a poor prognosis after parents witness resuscitation in the emergency department ▪ Referring a child with dysmorphic features to a genetics workup at their well child checkup ▪ Explaining the need to interview an adolescent in private	▪ Disclosing a new life-threatening/altering diagnosis ▪ Disclosing a medical error ▪ Delivering difficult news by telephone ▪ Talking to angry parents who have a child with an unclear diagnosis ▪ Having a "do not resuscitate" conversation with parents who speak a different language ▪ Discussing pain management with parents whose goals differ from those of the providers ▪ Notifying a family of a death

[a] Copies of the scenarios are available upon request from the authors.

BOX 1 Residents' Responses to the Postworkshop Question: "What Was the Most Valuable Idea/Concept You Learned Today?"

- "Being vulnerable/honest. Saying 'I don't know' can be powerful. The moment of breaking bad news is life changing and a special moment to be part of."
- "Be human. Be confident. Take responsibility."
- "Be prepared, be sincere, and be honest."
- "We have a whole team of resources! Remember to utilize the expertise of nurses, social workers, and chaplains."

Immediately prior to the workshops, residents completed questionnaires to assess prior training and experience in difficult conversations (PGY-1) and current confidence in engaging in these conversations (all residents). Immediately after the workshop, residents completed a second questionnaire to remeasure respective confidence levels and evaluate how they perceived the effectiveness of different workshop components. In 2015 and 2016, questionnaires were given to clinical care team members and parents after the workshop to ascertain their reasons for participating, assess parental session-related stress, and gauge subjective impressions on the workshop's effectiveness. Questionnaires were developed by the workshop's physician faculty and have not been tested for validity evidence.

To assess whether prior medical school education and experience in difficult conversations improved over time, a univariate analysis of variance was performed. Changes in knowledge and confidence before and after training were analyzed using the Mann-Whitney *U* test for unpaired data. Data from 2009 were excluded because a different survey tool was used. All data were analyzed using Microsoft Excel (Microsoft Corp, Redmond, WA) and SPSS version 23.0 (IBM Corp, Armonk, NY).

Results

Responses to the question, "Have you had any formal training/experience with delivering bad news?" from incoming PGY-1 residents demonstrated minimal exposure prior to residency (99% response rate [128 of 129 surveyed]), with a mean score of 2.18 on a 5-point Likert scale (1, none, to 5, significant). We found no significant differences in responses from 2008 to 2016 (excluding 2009) in terms of training ($F_{6,119} = 2.177$, $P = .43$) or experience ($F_{6,119} = 2.175$, $P = .45$).

The PGY-1 residents' self-reported confidence in having difficult conversations doubled following the training, from a median of 2 to 4 (99% response rate [128 of 129]; Mann-Whitney $U = 2292.5$; $P < .001$).

BOX 2 Clinical Care Team Members' Perceptions of Parent Involvement

- "[Using parents] made the conversations feel sacred and brought immediate weight to the topics at hand and the words being said. Their insight into how the messages are received is irreplaceable."
- "Parents are one of the most important parts of the role-play. They have real experiences and wisdom that actors could not reproduce in the same way."
- "Hearing the parent's viewpoint and past experiences during these sessions helped me anticipate issues that could arise and prepare better for the situation before I walk in the room. It also helped me identify my weaknesses or comfort level with difficult conversations."
- "[Parents] make the situation much more real and make you get in the moment."
- "Having actual parents here was extremely helpful and gave important insight into these situations."

A majority of PGY-1 residents (96%, 135 of 140) described the sessions as helpful or very helpful.

Postworkshop surveys asked PGY-1 residents to provide the most valuable idea or concept they learned. Their responses focused on the importance of empathic delivery, honesty, and inclusion of the health care team. Selected examples are shown in BOX 1.

A total of 91% (115 of 126) of PGY-2 residents (91% response rate [126 of 139]) reported that the workshop would increase their ability to deliver bad news by selecting 4 or 5 on a 5-point Likert scale (1, not at all, to 5, strongly agree). A total of 90% (114 of 126) described the sessions as either helpful or very helpful by selecting 4 or 5 on a 5-point Likert scale (1, not at all, to 5, strongly agree).

A total of 100% (37 of 37) of parents and clinical care team members agreed that the training would increase residents' ability to manage difficult conversations and selected a 4 or 5 on a 5-point Likert scale (1, not at all, to 5, strongly agree; 84% response rate [37 of 44]). Likewise, 100% (37 of 37) either agreed or strongly agreed that training increased residents' respect for an interprofessional approach to difficult conversations. Parents and clinical care team members unanimously reported that parents would be preferable to standardized actors for role-playing exercises of this type (84% response rate [37 of 44]). Clinical care team members' narrative responses reflected their perceptions of parents' involvement (BOX 2).

Although these sessions had the potential to trigger upsetting memories or concern regarding their children, only 1 parent found the role-playing exercises distressing. Parents referred to the positive, supportive, collaborative environment and the

satisfaction of using their experience to teach residents as reasons why they found the sessions to be valuable.

Discussion

Over 9 years of implementation, we found that a communication simulation workshop using parents of children with advanced illness and an interprofessional team in role-playing exercises consistently improved pediatrics residents' self-reported communication skills. This intervention was sustainable and highly accepted by residents, clinical care team members, and parents. We also found that many interns continue to begin residency with minimal formal training and experience.

There has been increasing interest in the use of patients and families as educators. Initially, patient and family involvement was focused on teaching physical examination and history-taking skills, but more recently it has expanded to include other aspects of medical education, including improving resident physicians' communication skills and understanding of patients' perspectives.[15–19] However, the use of patients or family members as opposed to standardized actors in simulated difficult conversations training is limited. We are aware of only 2 relevant studies (both published since we initiated our program) that use bereaved parent volunteers in role-playing exercises to train pediatrics residents and fellows.[20,21] The sessions in both studies were well received by participants and increased residents' and fellows' self-reported confidence and preparedness for difficult conversations. Our study results extend the important findings in these articles. In addition to physician faculty facilitators and parents, we also included nurses, social workers, and chaplains in our role-playing simulations. This interprofessional approach has been used to a limited extent by others in difficult conversations training and has been viewed favorably by participants.[4,22,23]

Although the longevity of our training program supports its acceptability, there are several challenges to its implementation. We have found that it is difficult to find protected time in a busy training program to focus on the emotionally challenging task of delivering bad news.[7,8,24] Including these sessions during orientation has been a successful solution at our institution. Limited financial resources are another hurdle.[7] Since inception of this program, we have relied on participants to volunteer their time for the half-day workshop. Identifying appropriate parent volunteers presents another challenge. Using a parent liaison recruited from a family advisory council or parent support group is an approach to consider. Similar to team members, parents report fulfillment in educating residents, and most return to participate in subsequent workshops.

This study has limitations. It was performed in one specialty at one institution, and therefore the results may not be widely generalizable. Residents' improvement in self-confidence and abilities was only measured immediately following the workshop, and actual behaviors with patients may not change or be sustained over time. Finally, the survey instrument does not have evidence of validity, and respondents may have interpreted questions differently than intended.

Our evaluation of the efficacy of the use of parents as opposed to actors was a noncomparative assessment. In the future, randomizing residents to our approach versus training that uses actors would clarify the value of parents and an interprofessional team as teachers.

Conclusion

This study of a novel educational model in teaching communication demonstrates the acceptability and sustainability of using parents instead of standardized actors in resident training for difficult conversations in pediatric practice. This interprofessional approach was well received and improved residents' immediate self-reported confidence in having these conversations.

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