

Development of an Institutional Resident Curriculum in Communication Skills

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Abstract

Objective We describe a collaboration between the graduate medical education office and the Henry Ford Health System's Office of Clinical Quality and Safety to create an institution-wide communication skills curriculum pertinent to the institution's safety and patient- and family-centered care initiatives.

Methods A multidisciplinary committee provided oversight for the curriculum design and used sentinel event and other quality and safety data to identify specific target areas. The curriculum consisted of 3 courses: "Informed Consent," "Sharing Bad News," and "Disclosure of Unanticipated Events." Each course included 3 components: a multimedia online module; small group discussions led by the program director that focused on the use of communication scripts; and 2 objective structured clinical examinations (OSCEs) requiring residents to demonstrate use of the communication scripts. All first-year residents (N = 145) and faculty (N = 30) from 20 residency programs

participated in this initiative. Evaluation of the residents consisted of a self-assessment; the standardized patients' assessment of the residents' performance; and faculty assessment of resident performance with verbal feedback.

Results Survey data showed that residents found the courses valuable, with residents identifying communication scripts they would use in clinical settings. Focus groups with faculty highlighted that the resident debriefing sessions provided them with insight into a resident's communication skills early in their training.

Conclusion Our institutional curriculum was developed in a collaborative manner, and used an evidence-based approach to teach communication skills relevant to institutional safety and quality initiatives. Other institutions may wish to adopt our strategy of departmental collaboration and alignment of resident education with institutional initiatives.

Editor's Note: The online version of this article contains a detailed description of the 3 courses developed in this curriculum: Informed Consent, Sharing Bad News, and Disclosure of Unanticipated Events. The authors/HFHS are agreeable to sharing this curriculum in a collaborative partnership with other institutions.

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Background

Physician communication is an important component of effective patient care.¹⁻⁴ The Accreditation Council for Graduate Medical Education (ACGME) mandates that residency programs teach and assess residents' interpersonal and communication skills during training.⁵ The Joint Commission, along with other national quality and safety organizations, now requires hospitals to provide patient- and family-centered care, disclose errors, develop standardized handoff strategies, and use translators for non-English-speaking patients.⁶ This environment offers rich opportunities to design institutional curricula in communications skills for residents that link ACGME accreditation mandates with national safety and patient- and family-centered care initiatives.

A variety of strategies have been offered for teaching these communication skills;⁷⁻¹¹ recommendations include using "teach back" during informed consent,^{12,13} adopting standardized handoff techniques to enhance the communication of critical patient information during transitions of care,¹² and

disclosing unanticipated events and errors to patients and their families.¹¹ Residency program directors and faculty often feel challenged to teach communication skills because historically they have not been trained to teach this competency domain.¹⁴ In this article we describe the collaboration between Henry Ford Health System (HFHS) Graduate Medical Education (GME) Office and the Office of Clinical Quality and Safety (OCQS) in creating an institution-wide communication skills curriculum for 20 diverse residency programs that addressed HFHS safety initiatives. Our curriculum adapted existing online multimedia modules developed by OCQS and was aligned with institutional initiatives to ensure sustainability.

Methods

Needs Assessment

In 2008, HFHS launched the “No Harm Campaign” designed to reduce harm events throughout the system by 50% over the course of 3 years. A multidisciplinary committee comprising residents, program directors, and representatives from quality and safety, nursing education, service excellence, and GME was formed. The committee agreed that courses consisting of an OCQS multimedia online module, small group discussion, and OSCE experience should be developed for the topics of “Informed Consent,” “Disclosure of Unanticipated Events,” and “Sharing Bad News” because those topic areas linked directly to the HFHS No Harm Campaign. The curriculum was mandatory for first-year residents in 20 residency programs ($N = 145$) and used communication scripts to teach these skills to residents (FIGURE). Program director buy-in was obtained by demonstrating a clear link to ACGME accreditation standards and by engaging them in the initial design process.

A literature review revealed OSCEs were one of the most effective ways to measure communication skills; therefore, we established a partnership with Wayne State University Standardized Patient Program to provide standardized patients.^{15,16} The OSCE scenarios were adapted from sentinel events at HFHS and focused on key communication issues that occurred in the 3 identified areas (TABLE 1). Residents completed a course evaluation form, and at the conclusion of the 3 courses, representative faculty from each program ($N = 30$) attended 1 of 3 hour-long focus groups during which they discussed the strengths and weakness of the 3 courses. The HFHS Institutional Review Board (IRB) approved this retrospective analysis.

Overview of Curriculum Design and Content

Within a week after completing the OCQS multimedia module, residents participated in a program-director–led small group discussion and completed 2 OSCE cases.

What was known

Communicating with patients about informed consent, “bad news,” and unanticipated events are critical skills for physicians.

What is new

An institution-wide communication skills curriculum includes modules for these circumstances.

Limitations

Outcomes are limited to resident acceptance of the curriculum.

Bottom line

Other institutions may consider adopting or adapting this evidence-based curriculum relevant to quality and patient safety.

The small group discussions focused on specialty-specific scenarios related to the 3 course topics and engaged the learner and faculty in more deliberate learning around the communication skill sets (TABLE 1). The courses were given in a specific sequence (Informed Consent, Disclosure of Unanticipated Events, and Sharing Bad News), in keeping with the concept that teaching communication scripts provides novices with a framework for difficult conversations.¹⁷ The time frame for completing all 3 courses varied depending on space in our simulation center and program schedules. TABLE 2 displays feasibility information.

Assessment

The OSCE cases were generic to allow residents from 20 different specialties to use the communication script. The OSCE scenarios were adapted from sentinel events that occurred at HFHS (TABLE 3). After each OSCE, residents completed a self-assessment using the Kalamazoo Essential Elements Communication Checklist (Adapted) (KEECC-A).¹⁸ Standardized patients also assessed resident performance and provided verbal feedback by using the KEECC-A. During the debriefing session, faculty completed the KEECC-A on the resident’s performance. The results have been described in an earlier article.¹⁹ The resident’s faculty mentor was able to review all assessments and discuss with the resident their performance and opportunities for improvement. This provided faculty with critical knowledge of each resident’s communication skills early in the first year.

The KEECC-A was chosen to evaluate residents’ communications skills because of its established reliability and validity in measuring communication skills.¹⁹ After completion of the 3 modules, program directors received a portfolio containing each resident’s average score on the OSCE, departmental average, and an institutional average.

Faculty Development

Faculty development sessions were offered to assist faculty ($N = 30$) in understanding more deeply the initiative and

Informed Consent:²⁰

“Please tell me back in your own words what we just discussed so I can clarify any questions you might have.”

OR

“When your friends asked you what we discussed, what will you say?”

Disclosure of Unanticipated Events:²¹

H	Hear	Ask patient/family what they know/suspect. Listen carefully; do not interrupt.
E	Empathize	Sit down; Do not appear rushed; Speak slowly in an even toned voice; Open body posture; Do not interrupt.
A	Apologize	“I am sorry the situation occurred...” Describe error; provide sufficient information to family for informed decision making; “What questions do you have?”
R	Respond	“Here is what we are doing to make sure it does not happen...”
T	Thank You	“I realize this is difficult to hear. I want to thank you for your time and for listening to us....What questions do you have?Here is my direct number for further questions...Would you like the assistance of the chaplain and/or Social Work?”

Sharing Bad News:²²

S	Setting	Find a setting that provides privacy, patient comfort, and uninterrupted time.
P	Perception	“What have you been told about your medical condition so far?”
I	Invitation	“I want to talk with you about your illness.”
K	Knowledge	“Unfortunately, I have some bad news to tell you...” Provide information in small chunks.
E	Empathize	“I know this must be hard for you to hear.”
S	Summary and Strategy	“Are you ready to begin discussing treatment options?”

FIGURE

EXAMPLE COMMUNICATION SCRIPTS

TABLE 1	EXAMPLES OF OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE) SCENARIOS		
Topic	Sentinel Event	OSCE Content	Key Learning Points
Informed consent	1. Inadequate informed consent	1. Consent for central line placement 2. Consent for blood transfusion in a patient with religious objections	Demonstrate teach back and use of everyday language
Disclosure of unanticipated events	1. Retained central line guidewire 2. Coumadin ^a overdose (illegible handwriting)	1. Apology for a retained guidewire 2. Apology for a Coumadin ^a overdose	Demonstrate use of the HEART model, including apology and accepting responsibility
Sharing bad news	1. Patient complaints related to insensitive delivery of bad news	1. Patient told they have recurrence of cancer 2. Obtaining DNR orders in a patient with end-stage congestive heart failure	Demonstrate use of the SPIKES model

Abbreviation: DNR, do not resuscitate.

^a Bristol-Myers Squibb, Princeton, New Jersey.

TABLE 2 FEASIBILITY OF INSTITUTIONAL CURRICULUM

Topic	Faculty Required, No.	Direct Costs (OSCE), \$	Run Time for Module, min
Informed consent	30	7000.00	45
Error disclosure	30	7000.00	45
Sharing bad news	30	7000.00	45

Abbreviation: OSCE, Objective Structured Clinical Examination.

assessment tool. Faculty were provided debriefing guides containing key learning points to emphasize the importance of accurate ratings and behavioral anchors for the KEECC-A to help them accurately rate residents. They reported that the facilitator and debriefing guides were the most helpful components because they provided them with explicit talking points and responses to possible questions from the residents.

Results

Program Evaluation and Improvement

Qualitative and quantitative methods were used for curricular evaluation and improvement. Residents ($N = 138$) completed a course evaluation after each of the modules launched in the 2008–2009 academic year, using separate 11-item scales for each of 3 modules: Informed Consent, Bad News, and Error Disclosure. Residents rated the effectiveness of the components of each module by using a 7-item questionnaire with a Likert scale. Four additional questions asked residents to estimate how frequently they would use the skill addressed in the module and to estimate their skill before and after the module.

Residents' mean ratings of the effectiveness of the entire curriculum was 4.32 ($SD = 0.49$) on a 5-point scale. Separate effectiveness ratings for the 3 modules are presented in TABLE 3. Within-subjects ANOVA identified significant differences in residents' mean ratings of the

TABLE 3 RESIDENTS' EFFECTIVENESS RATINGS FOR 3 LEARNING MODULES

Learning Module	N	Rating	
		Mean	SD
Informed consent	138	4.52	0.60
Sharing bad news	117	4.16	0.65
Error disclosure	114	4.23	0.59

Note: 1 = Never; 2 = Occasionally; 3 = occasionally (50% of time); 4 = fairly often (75% of time); 5 = very often (90% of time).

effectiveness of the 3 modules ($F_{2,210} = 24.79$, $P < .001$). Repeated contrasts revealed that residents rated the informed consent module higher than the error disclosure module ($P < .001$); however, there was no significant difference in effectiveness ratings of the error disclosure versus bad news modules ($P = .07$).

Paired samples t tests revealed significant improvements in residents' self-assessment of their skills for each module (TABLE 4). Residents consistently reported a greater sense of skill and knowledge across the domains after completing the modules. Furthermore, residents indicated that they would frequently use the skill addressed by each module (TABLE 5), and specifically, that they would use the informed consent techniques on nearly a daily basis.

Focus groups with teaching faculty provided additional qualitative data. Faculty reported, in general, that the 3 modules were valuable and the use of communication scripts helped residents develop language for challenging conversations. Faculty also gained insight into residents' communication skills, since these courses were given early during the first year. Faculty reported that they learned new information about key communication scripts and skills as a result of teaching the course. Scheduling the educational module was the faculty's biggest challenge and they suggested paying more careful attention to scheduling to accommodate clinic schedules. In addition, faculty recommended that 2 OSCEs per module were sufficient for the resident's exposure to the communication scripts.

TABLE 4 COMPARISON OF RESIDENTS' MEAN SELF-RATINGS OF THEIR KNOWLEDGE/SKILL BEFORE VERSUS AFTER 3 LEARNING MODULES (COURSE EVALUATION DATA)

Learning Module	Knowledge/Skill Before	Knowledge/Skill After	df	t	P
Informed consent	3.19	3.96	137	10.45	<.001
Sharing bad news	2.81	3.47	116	11.52	<.001
Error disclosure	2.71	3.53	113	12.04	<.001

Note: 1 = novice, 2 = advanced beginner, 3 = competent, 4 = proficient, 5 = expert.

TABLE 5 RESIDENTS' RATINGS OF HOW FREQUENTLY THEY WILL USE THE SKILL ADDRESSED IN EACH MODULE			
Learning Module	N	Mean	SD
Informed consent	138	4.32	1.00
Sharing bad news	117	3.32	1.17
Error disclosure	114	2.89	1.13

Note: 3 = monthly, 4 = weekly, 5 = daily.

Discussion

This article highlights a successful multidisciplinary collaboration between HFHS GME and the OCQS to develop unique curricula that reflect broader institutional and national agendas related to quality of care, patient safety, and interpersonal and communication skills. Curricular components adapted OCQS multimedia modules and added a small group discussion and a set of OSCEs. Communication scripts offered residents the necessary language for these conversations. Residents found these courses valuable. The curriculum allowed faculty to deepen their knowledge and skills in teaching communication skills, and faculty found these educational modules valuable, and the debriefing sessions provided them with insight into residents' communication skills early in their training.

The development and implementation of this curriculum provided a variety of important lessons. The incorporation and utilization of existing resources within HFHS opened doors to increased collaboration between GME and other departments within the hospital. The process of launching an institutional curriculum was initially daunting, but by paying attention to details, incorporating early feedback from program directors, and customizing education to the medical culture through the use of small group discussion and faculty teachers, we were able to achieve early successes. Developing educational experiences that linked directly to ACGME accreditation requirements was a "win" for program directors. This initiative also increased resident familiarity with institutional initiatives in the areas of quality and safety and patient- and family-centered care. Future research initiatives will be tied to identifying appropriate direct observation experiences that can link this training directly to residents' bedside performances.

This curriculum was launched within the context of a health care system supportive of quality and safety initiatives and resident education. The lack of such system-wide infrastructure or leadership support may make launching an institutional curriculum daunting and may limit the generalizability of this study in other institutions.

Other institutions may consider reducing interdepartmental silos by collaborating with others to capitalize on existing resources. The infrastructure will be different at each institution, but other institutions may wish to adopt our strategy of collaborating across departments to use existing institutional educational resources and aligning resident education with institutional initiatives.

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