Published in final edited form as:

J Am Geriatr Soc. 2012 February ; 60(2): 332–337. doi:10.1111/j.1532-5415.2011.03787.x.

Geritalk: Communication Skills Training for Geriatrics and Palliative Medicine Fellows

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Abstract

Expert communication is essential to high quality care for older patients with serious illness. While the importance of communication skills is widely recognized, formal curricula for teaching communication skills to geriatrics and palliative medicine fellows is often inadequate or unavailable. We drew upon the educational principles and format of an evidence-based, interactive teaching method, to develop an intensive communication skills training course designed specifically to address the common communication challenges faced by geriatrics and palliative medicine fellows. The 2-day retreat, held away from the hospital environment, included large-group overview presentations, small-group communication skills practice, and development of future skills practice commitment. Faculty received in-depth training in small-group facilitation techniques prior to the course. Geriatrics and palliative medicine fellows were recruited to participate in the course and 100% (n=18) enrolled. Overall satisfaction with the course was very high (mean 4.8 on 5-point scale). Compared to before the course, fellows reported an increase in self-assessed preparedness for specific communication challenges (mean increase 1.4 on 5-point scale, $p<0.01$). Two months after the course, fellows reported a high level of sustained skills practice (mean 4.3 on 5-point scale). In sum, the intensive communication skills program, tailored to the specific needs of geriatrics and palliative medicine fellows, improved fellows' self-assessed preparedness for challenging communication tasks and provided a model for ongoing deliberate practice of communication skills.

Keywords

3–5 Medical Education; Communication Skills; Geriatrics; Palliative Care

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Conflict of Interest: Drs. Back and Arnold received honoraria for their effort on this project and have also written a book on this topic that helped inform the intervention. Dr. O'Neill received a GACA to support Geritalk program development.

Author Contributions: AB, RA, AK and LO were involved in the development of the curriculum and study design; all authors participated as course faculty and contributed to the development and editing of the manuscript.

INTRODUCTION

The care of older adults frequently involves communication challenges. Delivering bad news, supporting a patient through periods of functional or cognitive decline, and establishing appropriate goals of care in the setting of serious or life-threatening illness are common challenges geriatricians face. Shared decision-making, a communication strategy that aims to match clinical care to individual goals and preferences, is promoted for clinical decisions as varied as cancer-screening to enrollment in hospice.(1, 2) These decisions, which are often complicated by prognostic uncertainty, require a nuanced conversation about patient values and goals and how these goals can be translated to a treatment plan.(1, 3–7) Patients and their families also value high-quality communication because it is fundamental to a therapeutic doctor-patient relationship.(8, 9)

Research suggests, however, the quality of communication between physicians and patients needs to be improved.(10–12) Poor communication compromises a physician's ability to assess and manage pain and other physical symptoms, as well as psychological issues including anxiety, depression, and adjustment to illness. Physicians often focus on technical aspects of diagnosis and treatment without eliciting patients' values and goals.(13) Indeed, doctor-patient communication is the area that receives the most negative comments from families of dying patients.(11) The quality of communication also influences patient and family satisfaction, compliance with medications, and clinical outcomes.(11, 12, 14–16) Finally, poor doctor-patient communication is correlated with increased rates of malpractice claims.(17)

Such findings have led the Medicare Payment Advisory Commission (MedPAC) to identify communication skills as a priority topic area from among the American Council of Graduate Medical Education (ACGME) common program requirements.(18) However, there exists a gap between the recognized importance of communication skills and the availability of structured educational programs for learning communication skills currently offered to fellows. Indeed, to our knowledge, few geriatric fellowship programs have formal curricula for teaching communication skills. Many geriatrics fellowships do incorporate a palliative care or hospice rotation, yet fellows report receiving the least instruction on complex communication tasks (e.g. telling a patient he or she is dying).(19)

Aiming to develop a communication skills training program tailored to the specific needs of geriatrics and palliative medicine fellows, we have drawn upon the educational principles and format of an evidence-based, interactive teaching method: Oncotalk.(20–23) The overall goal for the program, called Geritalk, was to improve fellows' communication skills with patients with serious illness and their families. In this paper, we describe the design, content and evaluation of the Geritalk communication skills program.

METHODS

Course Development

We combined geriatrics and palliative medicine fellows for both pragmatic and theoretical reasons. First, our institution's Department of Geriatrics and Palliative Medicine is home to the geriatrics and palliative medicine fellowship programs involved in the course and these programs share several existing curricular elements. Second, the combined group of fellows provided a "critical mass" sufficient for work in both large and small group arrangements. In addition, while distinct sub-specialties, geriatrics and palliative medicine share significant areas of overlap. Both sub-specialists care for many elderly patients with serious, progressive illness for whom palliative care, i.e., care centered on lessening the burden of

distressing symptoms and supporting the needs of patients and caregivers, is critical to high-quality care. The specific communication challenges that arise when interacting with these patients, such as giving bad news and negotiating goals of care, are common to both sub-specialties.

We started by assembling a list of core communication skills and common communication tasks that fellows in both sub-specialties should master.(24) We worked with the Program Directors from the Geriatrics and Palliative Medicine Fellowships at our institution, as well as our affiliated VA Palliative Medicine Fellowship, to develop this course within the context of the programs' shared year-long curriculum on communication skills. While fellows are drawn from three distinct fellowship programs, all attend two 1-hour department-wide didactic sessions focused on communication skills and participate in one simulated-patient session focused on giving bad news. In addition, one-on-one mentorship is provided by the attending geriatrician or palliative medicine physician to whom each fellow is assigned for their four-week inpatient rotations on the Mobile Acute Care for the Elderly (ACE) service, the Geriatrics Concurrent service, or the Palliative Care Consult service. All fellows complete 5 of these four-week rotations over the course of the academic year. In complement to these established curricular elements, this new course provides an immersion experience in focused communication skills training and provides a framework for ongoing practice and development of skills. We scheduled the course approximately mid-year in order to optimize the fellows' readiness to learn advanced communication skills. At this point in fellowship training, they have become proficient with many of the core principles and skills of the sub-specialty and have experienced several challenging communication encounters. These experiences provide a context for the new skills and the motivation to improve. The mid-year course also ensures that the fellows will have ample opportunity to practice the skills learned in the course with faculty supervision during the remainder of the year.

Educational Principles

Using Oncotalk as a model, we designed the program around the following educational concepts: (1) lecture-style methods alone are ineffective; (2) adult learning principles should be used; (3) teaching must include skills practice; (4) teaching must attend to learner attitudes and emotions; (5) the learning environment should integrate knowledge, skills, and attitudes; and (6) reinforcement is critical for the learning process.(23, 25, 26)

Setting

The program entailed an intensive 2-day retreat. The retreat was held away from the hospital setting and arrangements were made for coverage of the fellows' clinical responsibilities, thereby encouraging the learners to focus on the educational task at hand. The retreat was designed to create an environment where good communication was highly valued and learners could feel that they would be supported in the work required to acquire these skills. The social setting of the retreat also promoted informal learning among peers in the time outside of formal sessions.

Curriculum

The Geritalk curriculum involved the following three types of formal learning activities: large-group overview presentations, small-group communication skills practice, and future skills practice commitment.

Overview presentations

Large-group overview presentations were 25-minute sessions focused on a specific communication task. During these overview presentations, faculty grounded recommendations for communication in empirical research when possible. The sessions emphasized a step-by-step skills-based approach for the task, including specific language, and demonstrated the approach using faculty role-play. These sessions provided learners with a mental model to apply in the communication skills practice sessions. The topics for these sessions included Basic Communication Skills, Giving Bad News, Negotiating Goals of Care, and Forgoing Life-Sustaining Treatment, including Do-Not-Resuscitate Orders. After the retreat, fellows received a binder that included the slides from each presentation and relevant references.

Communication skills practice

After each overview presentation, a 2.5-hour skills practice session was conducted focusing on the skills discussed in the preceding didactic session. These were small group sessions consisting of 5–6 fellows and 2 faculty facilitators. The high faculty-to-learner ratio ensured that all participants had several opportunities to practice directly in simulated situations; received individual feedback from faculty and other learners; and observed other participants and provided them with feedback. Because most participants were anxious about interviewing in front of others and because their previous experiences with feedback were often negative, the faculty were careful to set ground rules and to establish a tone in which experimentation was encouraged and skill development was rewarded.

The small-group skills practice is based on learner interactions with patient or family-member actors. Three actors played a single patient or family-member, who moved through a trajectory of illness during the four successive practice sessions over the course of the two-day retreat. Each of the 3 cases was developed specifically for geriatrics and palliative medicine fellows, taking care to ensure that each patient's case mirrored a common clinical scenario in geriatrics and palliative care. Box 1 provides a summary of one case with the target skills and goals for each session. These actors received written character profiles beforehand, as well as 1 day of training in responding genuinely to the fellow's communication and providing feedback. Each case was written with specific instructions for the actor, directing him how to respond depending on the skills exhibited by the fellow. In this way, the actors had the flexibility of tailoring their "in character" response to varied levels of learners, from the early learner to the more advanced one. Each patient or family-member actor had 30 minutes with each small group, which allowed for a brief setup (in which the facilitator explained the clinical situation, asked for a volunteer, and discussed goals for the encounter), the interview (typically no more than 5 minutes), and a short debriefing (which included structured feedback and the option to replay part of the interview using a revised approach). The other group members provided feedback about the specific skill the practicing fellow asked them to observe (for example, "what words or statements did the doctor use to respond to the patient's emotion?"). This structure maximized practice time, minimized time spent intellectualizing about how to communicate and helped approximate some of the time pressures clinicians normally face. In addition, faculty emphasized the model of deliberate practice, i.e., identifying a skill to work on before an encounter and reflecting on what went well and what could be done differently after an encounter, as a method for ongoing skill development.(27)

Future skills practice commitment

At the end of the retreat, learners identified two communication skills that they committed to practice within the next month. This commitment to try newly learned techniques is important to behavior change. Learners recorded these two skills in a note, which they

addressed to themselves. Approximately a month after the retreat, the notes cards were mailed to each learner as a reminder of their learning commitment. Two months after the retreat, learners were asked to complete a course evaluation that assessed how frequently they had practiced new communication skills and their ongoing commitment to continued practice and behavior change.

Faculty Role and Expertise

The 6 course faculty were assembled from among the attending physicians on the Geriatric Medicine and Palliative Care hospital services. 2 are board-certified in Palliative Care, 1 in Geriatrics, and 3 have both Palliative Care and Geriatrics certification. In the overview sessions, the faculty used standard techniques for giving interactive presentations. In the skills practice sessions, however, the faculty played a role that was more coach than expert and relied on small-group facilitation techniques. In preparation for this role, all faculty participated in intensive facilitation training designed specifically for Geritalk and averaging 6 days over several months preceding the course.(28, 29) The faculty goal in the skills practice sessions was to create a safe atmosphere in which learners could express concerns, receive and give constructive feedback, and reflect on their performance. Faculty skills in monitoring and intervening in group processes were critically important to maintain focus and to set a tone that encouraged trying out new skills. The interactions between fellows and patient or family-member actors were treated as raw material that provided opportunities to introduce concepts and principles, and to elicit deeper discussion. Difficult communication problems were treated as situations to be solved jointly by the entire learning group. Occasionally, faculty paused to explore a learner's self-awareness and insight to promote the skills of being a reflective practitioner. In this way, fellows learned to practice deliberately.

Measurements

The program evaluation, in the form of 3 anonymous surveys, included a baseline assessment, process measures, such as learner satisfaction, and outcome measures. The outcome measures included self-assessment of preparedness for specific communication challenges and frequency of skills practice over the 2 months following the course. We selected these outcome measures because persistent and deliberate practice is fundamental to development of communication skills, particularly at the fellowship level. In addition, we did not solicit a self-assessment of skill level due to concerns about validity and reliability of this measure. The Mount Sinai School of Medicine institutional review board approved all evaluation procedures.

RESULTS

We recruited 11 geriatrics and 5 palliative medicine fellows, 88% in the first year of their fellowship. 14 had completed Internal Medicine residency training and 2 complete Family Medicine residencies. The median age was 32 years and the group included 9 women and 7 men. While participation in the program was voluntary, 100% of the eligible fellows enrolled in the program.

Baseline Assessment

Geriatrics and palliative medicine fellows who attended this program represented a self-selected group of physicians interested in acquiring communication skills. Still, more than half of the fellows (53%) reported no special training in communication during residency. Among those who reported prior didactic or bedside teaching, the most common topics included 'giving bad news to a patient' (65%) and "discussing code status/ do not resuscitate" (59%). At baseline, there was no significant difference between the geriatrics

and palliative medicine fellows' prior communication training or self-assessment of preparedness for challenging communication tasks.

Learner Satisfaction

The fellows' satisfaction ratings for specific aspects of the course are detailed in Table 1. Overall, they were very enthusiastic. They rated "the importance of the training to the development of your own clinical skills" 4.8 on a 5 point Likert scale and rated the statement "I would recommend this training to other fellows" 4.9 on a 5 point Likert scale. One fellow wrote, "This was an outstanding experience. To remove all clinical distractions allowed us to fully immerse ourselves in the subject matter, making the experience more powerful. The brief lectures followed by the practice sessions provided balance of learning." Another fellow stated, "I didn't realize how uncomfortable certain communication roadblocks made me feel...now I understand how to navigate them effectively and skillfully." Although these comments represent anecdotal data, they illustrate an intense engagement with communication skills by fellows who had little previous training and who attended the program based on interest rather than past positive experience. One fellow added, "Communication is the geriatrician's procedure. These topics are complicated and emotional making them easy to ignore yet essential to discuss. Geritalk is by far the best essential course I've taken."

Learner Preparedness for Communication Challenges

We asked learners to evaluate their preparedness for specific communication challenges before the course, as well as immediately after the course. Results are reported in Table 2. Overall, learners reported that at baseline they felt "somewhat prepared", 2.9 on a 5 point Likert scale. After the course, on average, they felt "well prepared", 4.3 on the same scale ($p<0.01$).

Skills Practice over Two Months after Course

Two months after completion of the Geritalk course, we asked the fellows to report how much they had practiced specific communication skills over the last two months. On a Likert scale, where 1 is "not at all" and 5 is "a great deal", fellows reported frequent practice of "avoiding jargon" (4.3), "expressing empathy" (4.4), "exploring with open-ended questions" (4.4), and "asking family members what the patient would have wanted" (4.4).

DISCUSSION

This novel educational intervention was tailored to the specific needs of geriatrics and palliative medicine fellows and designed to complement and expand the existing fellowship curricula. The course was based on rigorously evaluated programs in the medical literature demonstrating the effectiveness of communication skills training, in particular Oncotalk, and combined didactic and learner-centered approaches. The retreat was designed around a specific set of communication tasks, which enabled us to compose overview sessions and small group practice sessions that all support the curriculum objectives; while within each session, faculty facilitators encouraged learners to focus on the aspects of each task that represent their individual learning goals. Finally, using actors portraying patients at defined points in an illness trajectory enabled fellows to begin learning from their usual role as physicians by introducing them to the concept and value of deliberate practice of communication skills. The actors were able to introduce a convincing degree of emotion and respond to fellows in a way that reinforced skills and success. Thus, the learning situation aimed to promote skills, attitudes, and self-efficacy.

In our experience, the course was both feasible and effective. The fellowship program directors agreed that communication skills training is a priority for the education of future geriatricians and palliative medicine physicians. With their commitment and leadership, we secured the fellows' time away from clinical duties and resources for patient-actors. The course faculty also made a substantial commitment by devoting several days to intensive facilitator training. The fellows, in turn, recognized and valued this commitment to their education, as reflected in the 100% participation rate and the high learner satisfaction with the course. We also found a significant increase in self-assessed preparedness for specific communication challenges and a self-reported high frequency of deliberate skills practice in the clinical setting after the course. In this learner population, physicians who have chosen sub-specialties known to require advanced communication skills, these findings are particularly encouraging. Some learners expressed interest in a follow-up course or "skills consolidation" session and we are considering ways to incorporate this idea into the curriculum in the future.

Our evaluation of the program's effectiveness was, however, limited by the small number of participants. Due to feasibility, outcome measures were restricted to self-assessment, rather than direct observation of communication skills, and these measures are subject to bias. We also could not assess the impact of this communication training on patient or family outcomes. In estimating frequency of skills practice, we recognize that some fellows may have had more clinically appropriate opportunities for practice than other fellows. Despite these limitations, our data suggest the Geritalk program improved geriatrics and palliative medicine fellows' preparedness for challenging communication tasks and provided a model for ongoing deliberate practice of communication skills.

In conclusion, we have described a communication skills program: designed for geriatrics and palliative medicine fellows; based upon previously reported research and incorporating current adult-learning theory; and focused on the specific needs of the fellows at their particular point in professional development. The specialized "procedure" of geriatricians and palliative medicine clinicians is skilled communication in the setting of the most challenging clinical situations. With excellence as the goal, we believe the Geritalk communication skills training program provides fellows with essential communication skills training and a framework for continued deliberate practice.

Box 1. Example Case and 4 Skills Practice Sessions

RB is a 77 year-old woman, nursing home resident, admitted to the Geriatrics hospital service with pneumonia. Her past medical history includes hypertension, chronic renal insufficiency, and moderate dementia.

Session 1, Basic Communication Skills

On the morning after her admission, she is not awake or alert and appears ill: oxygen saturation 92% on 4 liters of oxygen, BP 88/40 and heart rate 120. Her son is asking to speak with the doctor.

Skills to practice:

- Elicit son's understanding of illness
- Provide clear additional explanation of situation and plan for treatment
- Attend to emotion

Goals for session:

- Son has a clear understanding of the current medical situation and proposed treatment plan.
- Establish rapport with son by recognizing how difficult this is for him.

Session 2, Giving Bad News

One day later her respiratory status deteriorated and repeat CXR reveals bilateral infiltrates consistent with ARDS. She is hypotensive and was started on dopamine by the critical care team. They think she will likely need to be intubated within the hour. Her son had told them to “do everything.”

Skills to practice:

- Deliver bad news (RB is much sicker and might not survive this hospitalization)
- Attend to emotion

Goals for session:

- Son understands the gravity of his mother’s situation and understands that the doctors will be doing everything they can to treat her infection and breathing problems, but that she is very sick and may die from her illness.

Session 3, Negotiating Goals of Care

Three days later, RB remains in the ICU. She is intubated, on 2 vasopressors, and has shown no signs of improvement despite aggressive critical care. The ICU team is requesting help in clarifying goals of care. The son has expressed he is hoping for a miracle.

Skills to practice:

- Deal with conflict by identifying shared interests and finding common ground
- Help son focus on what his mom would want
- Gather information about the patient’s wishes and brainstorm ways to meet her goals

Goals for session:

- Agree to a plan to seek spiritual support through RB’s parish for both RB and son.

Session 4, Forgoing Life-Sustaining Treatment

One week later, RB’s son brings in a written advance directive found by the nursing home staff. The Living Will states that if she ever had a terminal condition from which the doctors felt there was little or no hope for recovery, RB would not want to be maintained on artificial life support. The son wants to meet with you and to discuss next steps.

Skills to practice:

- Confirm the son’s understanding of his mother’s wishes
- Clearly explain the process of ventilator withdrawal and treatments focused on comfort
- Attend to sadness and other emotions

Goals for session:

- Honoring his mother's wishes, son agrees with ventilator withdrawal and aggressive symptom management.

Acknowledgments

The authors would like to acknowledge the dedicated support of Diane Maguire, the Geriatric Program Coordinator, and Dr. Helen Fernandez, the Geriatrics Fellowship Program Director. While course materials are not currently publicly available, the authors are available to consult with programs wishing to learn more about course development.

Funding Sources: This work was supported by Geriatric Academic Career Award (GACA) (1 K01 HP00160-01), HRSA Geriatric Training for Physicians and Dentists grant (D01HP19044), the Hertzberg Palliative Care Institute at the Mount Sinai School of Medicine, and the Mount Sinai Hospital Auxiliary Board. Dr. Kelley was supported by the Brookdale Foundation Leadership in Aging Fellowship; Dr. O'Neill was supported by GACA (K01 HP00160-01); Dr. Littrivis is supported by GACA (K01HP20483). Dr. Smith was supported by a Clinical Translational and Science Award (KL2 5KL2RR029885-02). Drs. Back and Arnold were supported by NIH R25 119019.

Sponsor's Role: None.

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Table 1**Learner Satisfaction with Geritalk Course**

Survey Item:	Mean Response[*]
How would you rate the importance of the training to the development of your own clinical skills?	4.8
Usefulness of interactive didactic sessions?	4.7
Usefulness of communication skills small group practice sessions?	4.9
Effectiveness of the small group leaders?	4.9
Usefulness of actors in small group sessions?	5.0
Usefulness of reflective exercises (e.g. "Taking it home session")?	4.6
Overall, how would you rate the educational quality of the program?	4.9
I would recommend this training to other fellows.	4.9
This should be required of all Geriatrics fellows.	4.9
This should be required of all Palliative Care fellows.	5.0
Commitment to changing 2 self-identified communication behaviors.	4.8

* Likert Scale: 1= Not At All, 3= A Little Bit, 5=A Great Deal

Table 2**Learner Preparedness for Communication Tasks Before and After Course**

“Overall, how well prepared do you feel you are to:”	Before Course *	After Course *
Express empathy?	3.4	4.7 [†]
Conduct a family conference?	3.1	4.4 [†]
Give bad news to a patient about their illness?	3.1	4.5 [†]
Elicit a family’s concerns at the end of a patient’s life?	2.9	4.6 [†]
Discuss various treatment options, including comfort care, with families of seriously ill patients?	3	4.4 [†]
Respond to family members who want treatments that you believe are not indicated?	2.5	4.2 [†]
Discuss religious or spiritual issues with patients?	2.8	3.8 [†]
Discuss code status (Do Not Resuscitate), with a patient?	3.3	4.3 [†]
Discuss discontinuing life-sustaining treatments with a family?	2.9	4.3 [†]
Summary Score across all Skills	2.9	4.3 [†]

* Likert Scale: 1= Not Well Prepared, 5=Very Well Prepared

[†] p value <0.01