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Communication Skills Curriculum for Foreign Medical Graduates in an Internal Medicine Residency Program

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Abstract

Background—Effective communication is an important aspect of caring for the elderly, who are more likely to have multimorbidity, limited health literacy and psychosocial barriers to care. About half of Internal Medicine (IM) trainees in the United States are foreign medical graduates, and may not have been exposed to prior communication skills education. This novel communication skills curriculum for IM interns aimed to increase trainees' confidence and use of specific communication tools with older adults, particularly in delivering bad news and conducting family meetings.

Methods—The workshop consisted of 2 interactive sessions, in a small group with 2 learners and 1–2 facilitators, during the Geriatrics block of the internship year. Twenty-three IM interns were surveyed at the beginning and at the end of the 4-week block and at 3 months after completion of the workshop about their knowledge, confidence and skill in communication, and asked about any challenges to effective communication with older patients. The primary outcome measure was change in self-reported confidence and behavior in communication at 4 weeks.

Results—On a 4-point Likert scale, there was an average improvement of 0.70 in self-reported confidence in communication, which sustained at 3 months after completion of the workshop. Participants reported several patient, physician and system barriers to effective communication.

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Conclusion—Communication skills education in a small-group setting and the opportunity for repeated practice and self-reflection resulted in sustained increase in overall confidence among IM interns in communication with older adults, and may help overcome certain patient and physician-specific communication barriers.

Keywords

communication skills; foreign medical graduates; internal medicine residency

Introduction

Effective communication is a major component of caring for the elderly, and is known to be associated with increased patient and physician satisfaction and adherence to treatment.¹ Examples include discussions regarding polypharmacy, advance care planning, cancer screening and treatment, or consent for a procedure or surgery. Older adults are also more likely to have lower than average health literacy, which can be a significant challenge for high quality care as medical comorbidities and complexity of care continue to increase with age.² Failure of communication can cause considerable mortality and morbidity from medical errors and is one of the leading causes of adverse events.^{3,4}

The Accreditation Council for Graduate Medical Education (ACGME) has designated Interpersonal and Communication Skills (ICS) as one of six core competencies to be fulfilled by residency programs.⁵ Some teaching models have been successful in introducing deliberate practice of specific skills among trainees in certain specialties that deal predominantly with the elderly, like oncology, geriatrics and palliative medicine.^{6,7} However, these programs are not widely disseminated and currently reach very few learners.

Foreign Medical Graduates (FMG) increasingly account for the majority of primary care residency positions, with about 50% of the Internal Medicine (IM) and Family Medicine (FM) residency spots being filled by FMGs in 2013.⁸ Many of these FMGs graduate from medical schools in countries where formal or informal education on communication skills is not yet a required part of the curriculum.⁹ While clinical skills competency and basic language proficiency are reviewed by the United States Medical Licensing Examination process, there may be a discrepancy in the ICS competency between FMGs and the US medical graduates when entering residency training. IM and FM house staff make important clinical decisions, often independently, based upon their communication with patients, thereby directly impacting patient safety and satisfaction.

This work describes the development, implementation and one-year evaluation of a novel curriculum designed to enhance IM residents' confidence in their communication with older patients, including discussion of bad news with patients and their families, through repeated practice of evidence-based communication strategies, at a Veteran Affairs Medical Center (VAMC) in New York City.

Methods

Needs Assessment

Given the lack of uniform communication skills among entering IM residents and the absence of a structured communication skills curriculum, we completed an informal needs assessment at an education committee meeting of the IM residency program and the Geriatrics Division at an urban VAMC. Educators felt that targeting incoming residents in their first year with this curriculum could maximally impact the learners' communication skills and their patient care in subsequent years of training and practice.

Setting and Subjects

The Geriatrics Division hosts a mandatory 4-week Geriatrics block for IM residents in their internship. The learning is built around a geriatrics consultation model with tutoring by Geriatrics and Palliative Medicine fellows and faculty. Two IM residents complete the block at one time, hence, one-on-one learning with fellows and faculty is possible. On a typical day, residents see between 2-10 patients, including new consults and follow-up evaluations. This block, therefore, provides an ideal setting for a structured curriculum to teach and practice specific communication skills.

Curriculum Description

Educational Strategies and Structure—The curriculum employs small group discussion, case-based learning and repeated practice with role-play exercises to engage these adult learners and develop an active learning model. The small-group setting with 2 learners and 1-2 facilitators ensures a safe and comfortable learning environment. Content is delivered in 2 interactive sessions, each lasting 1-1.5 hours, in 2 consecutive weeks of every 4-week block.

Curriculum Content—The first session (*Opening Channels of Communication*) is an introductory session with a 15-minute didactic on the importance of communication in physician-patient relationship and in geriatrics. This is followed by identification of perceived barriers to communication and discussion of specific situations where learners “felt stuck”. Next, communication tools such as Active Listening, “Tell me more” statements and the “Ask-Tell-Ask” strategy are introduced and discussed. Briefly, Active Listening is a structured way of listening attentively and includes 3 key elements in communication: comprehending, retaining and then responding.¹⁰ “Tell me more” phrase is an open-ended prompt that explores the patient's experience and makes the interaction more patient-focused.¹¹ “Ask-Tell-Ask”, wherein the physician asks what the patient knows currently, then tells what he/she needs to know, and then asks to ascertain understanding of information given, provides a simple framework for the physician to tailor information to the patient's needs and literacy level.^{12,13} Next, the learners use role-play to practice and reinforce the skills learnt during the session. They may choose to practice with standardized cases developed by the authors or one of their own challenging scenarios.

The second session (*Breaking Bad News*) begins by exploring challenges faced by learners when discussing sensitive issues with patients and family members, through description of

specific past clinical experiences. An introduction and discussion of the SPIKES strategy and “I wish ...” statements follows. SPIKES was originally developed for oncologists to assist with discussion of bad news with cancer patients and incorporates active acknowledgment of the patient or family's emotions.^{14,15} The word SPIKES serves as a mnemonic for the components of a complicated discussion, namely **S**etting up, assessing patient's **P**erception, obtaining patient's **I**nvitation, giving **K**nowledge / information, addressing **E**motions and **S**trategizing and **S**ummarizing for the patient. The “I wish ...” phrase (e.g., “I wish things were different”) can be a valuable tool to express empathy in the setting of bad news, instead of “I'm sorry”.¹⁶ The learners then use role-play to practice specific skills learned during the session in a simulated challenging situation. An attempt is made to explore different types of “bad news” (cancer diagnosis, HIV positive blood test, poor prognosis in an ICU patient), so that the learning may be relevant to the participants' clinical care. In both sessions, we encouraged self-reflection from the learner by helping them identify their own strengths and limitations right after the role-play. The facilitators also provided formative feedback.

Implementation

The IM residency program and the Geriatrics Division supported the educational program with mentoring, space and administrative support. Time commitment for the program from the learners was only 3-4 hours over the 4-week block, hence, did not interfere with clinical duties. The authors held monthly meetings for the first 3 months and quarterly meetings thereafter to review implementation issues. The educational intervention and evaluation protocol were approved by the Institutional Review Board of the VAMC where the program was conducted.

Curriculum Evaluation

Baseline and Post-intervention Knowledge and Skill Evaluation—We surveyed participants with a pre-test questionnaire prior to the first session and a post-test questionnaire at the completion of the block (about 2 weeks after the second session). We also administered a follow-up questionnaire at 3 months after the completion of the block via SurveyMonkey®. In these surveys, we asked about their prior communication training, knowledge of specific communication strategies, self-reported comfort and confidence in their communication skills in different settings and the frequency of use of specific communication tools. We used a 4-point Likert scale to elicit level of confidence or comfort level (1= minimal, 2=low, 3=medium and 4=high) in 6 situations. Via open-ended questions, we also asked learners to describe any perceived challenges to effective communication with older patients. We collected limited demographic information and no personal identifiable information, and responses were analyzed in aggregate.

Curricular Assessment—We requested feedback from the residents in the post-test and the 3-month follow-up questionnaires, and included items on the usability of the skills learned, aspects of the program they found most helpful for their learning and any changes they would suggest for future learners.

Competency Evaluation—Interns are evaluated by IM faculty at the end of every 4-week block in each of the six ACGME competencies on a scale of 1-9. We extracted the ICS competency rating for the interns from the faculty evaluations of the preceding and subsequent blocks, and computed the difference in order to determine impact of the communication skills curriculum in the Geriatrics block. Faculty were blinded to the interns' participation in the curriculum.

Results

Resident Participants

All 26 IM interns completed the Geriatrics block during the academic year 2011-12, of which 3 interns completed their block before the initiation of this curriculum. The remaining 23 interns completed the communication skills curriculum; all of them completed the pre-test questionnaire; 22 completed the post-test questionnaire; and 13 completed the online 3-month follow-up questionnaire. All 23 interns were FMGs and as shown in Table 1, the majority was male, above the age of 30 years and had graduated from medical school more than three years prior. Although 16 out of 23 interns received medical school instruction in English, only five acknowledged that they had any kind of training in communication skills in medical school. Of these five respondents, four received informal bedside teaching, and two of them received formal didactic training; all five considered their prior communication skills training to be insufficient.

Challenges to Effective Communication

Learners reported several specific challenges to effective communication with elderly patients and families (Table 2). The most commonly reported communication challenges included patient specific factors like hearing and visual deficits, and neurodegenerative and psychiatric disorders. Other factors included physician factors like discomfort in delivering bad news and system factors like lack of interpreter services and limited duration of visit time.

Active Listening and Ask-Tell-Ask Skills

At baseline, 80% of those who had received prior communication skills training had heard of Active Listening as a way to enhance communication with patients, yet none knew of the more specific Ask-Tell-Ask tool. At the completion of the workshop (n=22), 36% of the interns found the Ask-Tell-Ask to be very helpful. At 3 months after completion of the workshop (n=13), 62% of the respondents were using the Active Listening technique while 77% were using the Ask-Tell-Ask technique in their interaction with patients; 69% of the respondents found Ask-tell-Ask to be easy to integrate in their practice.

Spikes

At baseline, none of the 23 interns had learned the SPIKES protocol for discussing bad news. At the completion of the workshop (n=23), 64% of the participants felt that the SPIKES mnemonic was the most helpful skill they learned in the workshop; 77% said they were very likely to use the SPIKES method to communicate bad news to their patients and

families. At 3 months after completion of the workshop (n=13), while 38% of the respondents were using the SPIKES method, only 15% of the respondents felt that SPIKES was easy to use in their interactions with patients.

Baseline Confidence in Communication Skills

There was considerable variability in level of self-reported confidence in communication skills among IM interns at baseline, particularly with discussing bad news with patient and with family, and with discussing advance directives with patient. On the 4-point scale, the average overall confidence was 2.74. The interns were least confident in delivering bad news to a patient, with an average score of 2.48, followed by discussing bad news with the family (2.57) and in leading a family meeting (2.60) (Figure 1).

Post-intervention Change in Self-Reported Confidence in Communication Skills

Overall self-reported confidence among interns in communicating with older adults increased an average 0.70 points to 3.43 on the 4-point scale. Greatest improvement (0.88 points) was seen in interns' confidence in discussing bad news with a patient. At 3 months after the completion of the workshop, self-reported confidence in communication remained high at 3.46, for an average improvement of 0.73 points over baseline.

Participants' Evaluation of Curriculum

Most (91%) of the participants found the amount of information disseminated in the curriculum to be "just right". Eighty-one percent and 33% of the participants felt that the opportunity for repeated practice and the small group learning environment was helpful in enhancing their skills respectively. When asked about what changes they would recommend to the curriculum, 23% of participants preferred no change; 36% would have liked more opportunity to practice in a safe environment; and 14% would have liked greater use of audio-visual aids.

Post-Intervention Change in Competency Score

Average rating in the ICS competency by faculty evaluators in the block preceding the communication skills curriculum was 6.57, and the average rating in the same competency in the subsequent block was 7.70, indicating an improvement in average competency rating by 1.13 points.

Feedback from Faculty

The two facilitators of the curriculum reported high levels of satisfaction in running the small group sessions and did not feel the need to make any changes in content and format through the entire academic year. Key geriatrics and IM faculty involved in resident education provided support and subjective appreciation of the efforts.

Discussion

This study illustrates the variety and variability in the demographic characteristics and baseline communication skills among IM trainees at an urban VAMC today. At the outset, the participants in this study noted several challenges to effective communication with older

patients. These included patient-specific factors like comorbid conditions, psychiatric illness, speech and hearing deficits and polypharmacy as well as physician-specific factors like discomfort with breaking bad news. This communication skills workshop aimed to increase confidence by providing a toolbox of several simple and practical communication techniques that trainees can use to overcome some of these barriers.

None of the participants were familiar with either the Ask-Tell-Ask or SPIKES strategies at the outset. At 3 months after the program, the majority of the respondents was using the Ask-Tell-Ask, and felt comfortable doing it, which indicates that Ask-Tell-Ask may be easy to disseminate and utilize in daily encounters. Notably, very few interns perceived the SPIKES protocol for discussing bad news as being easy to incorporate in their practice. This may be due to the multiple steps involved in the process of discussing bad news, the need for mastery of cognitive as well as emotional content, and lack of repeated practice in a real or simulated setting. Complex communication skills, such as SPIKES, likely need reinforcement with regularly spaced practice opportunities and structured evaluation and feedback.

Our education intervention resulted in improvements in self-reported confidence in communication skills. Improvements were greatest in the area of discussion of bad news with patients and families and of advance care planning. Importantly, we demonstrate that the improvement in self-reported confidence was sustained at 3 months after the completion of the program, indicating potential for future behavior and practice change. Our work also reinforces the idea that active learning via role-play and cooperative learning and in small groups makes education more learner-centric, thereby increasing learner engagement and self-reported confidence. The high rate of participation and satisfaction among interns could also be attributed to the integration of this educational program in a geriatrics clinical block, which allowed interns to practice their learning in real patient situations, with expert supervision and feedback.

In addition to improvements in self-reported confidence, our curriculum resulted in a greater than 1 point increase in IM faculty rating of the interns' ICS competency on a standard 9 point scale. Because our study lacks a comparison group, it is possible that a portion of this improvement was a result of the natural progression of interns' achievement of proficiency. Nevertheless, we think that an improvement in ratings by IM faculty, blinded to the specific content of the communication skills training course, within a relatively short assessment period of 12 weeks is a significant change, and likely a consequence of this unique curriculum.

There are several other limitations to our study. The small sample size limits the power needed to assess statistical significance of the improvements observed and the single institution setting limits the generalizability of the results presented. Moreover, the data from 3 months after completion of the program is obtained from only 13 respondents to the SurveyMonkey® questionnaire and hence, may represent a selection bias. Although we found positive change in self-reported confidence and communication behaviors, these reports may not truly reflect change in behavior and practice patterns. Longer follow-up and specific evaluation methods are needed to demonstrate this. Finally, the reproducibility of

this program is contingent on the presence of interested and skilled facilitators in residency programs and time and/or resources to facilitate in the safe environment of small groups. Despite these limitations, we note that this curriculum may begin to address an important gap faced by many IM and FM residency program directors with the coming of the Next Accreditation System, particularly in the evaluation of communication skills competency.^{17,18}

In conclusion, our 2-session interactive educational workshop targeted at IM interns at an urban VAMC, all of whom were FMGs with minimal prior communication skills training, resulted in improvements in self-reported confidence and use of specific communication tools in clinical encounters. These changes were sustained at 3 months after completion of the workshop. Participants were highly satisfied with the evidence-based curriculum and its incorporation into the IM residency program was feasible. We suggest that residency programs with a high proportion of FMGs incorporate this curriculum by utilizing the teaching guides and evaluation material that are available on the Portal of Geriatrics Online Education (POGOe).¹⁹

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FIGURE. Change in Self-Reported Confidence after Communication Skills Workshop

Table 1
Demographic Information of IM Interns (n=23)

Age		Sex	
30 yr	10	Male	18
31-35 yr	7	Female	5
36-40 yr	2		
> 40 yr	4		
Language of Medical School Instruction		Time since Medical School Graduation	
English	16	1 yr	0
Serbian	3	1-3 yr	4
Others *	4	3-5 yr	8
		> 5 yr	11

* Includes Arabic, Burmese, Chinese and French

Table 2
Perceived Challenges to Effective Communication with Geriatric Patients among Internal Medicine House Staff

Patient Factors	Physician Factors	System Factors
Speech and hearing impairments	Discomfort in discussing bad news	Time constraints
Dementia, delirium and psychiatric illness	Discussions involving goals of care, poor prognosis	Language barrier / lack of interpreter services
Multiple comorbidities	Inability to build close rapport and trust	
Polypharmacy	Difficulty in prioritizing geriatric problem	
Patient perception of training physicians		