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Communication training for inter-specialty clinicians

Tessie W. October, MD, MPH^{a,b}, Zoelle B. Dizon, BA^a, Melinda F. Hamilton, MD^c, Vanessa N. Madrigal, MD^{a,b}, and Robert M. Arnold, MD^d

^aDivision of Critical Care Medicine, Children's National Health Systems, 111 Michigan Avenue NW, Washington, DC, 20010, USA

^bDepartment of Pediatrics, George Washington University School of Medicine, 2300 Eye Street NW, Washington, DC, 20052, USA

^cDivision of Pediatric Critical Care Medicine, Children's Hospital of Pittsburgh of University of Pittsburgh Medical Center, 4401 Penn Avenue, Pittsburgh, PA, 15224, USA

^dSection of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh Medical Center, 200 Lothrop Street, Pittsburgh, PA, 15213, USA

Summary

Background—Inter-specialty clinicians often co-lead family conferences for hospitalized patients. Families frequently report not receiving the same message from different clinicians. We developed a communication training workshop that crosses disciplines and co-trains clinicians in one setting to create a culture of delivering a unified message.

Methods—We developed a 2-day pediatric communication skills workshop to teach skills necessary to conduct a family conference. The workshop was targeted at nurse practitioners and faculty clinicians representing different specialties who co-manage children in an intensive care unit. Our primary outcome measure was learner-self assessment of skills attainment and workshop satisfaction. We also evaluated feasibility of recruiting busy clinicians.

Corresponding Author: Tessie W. October, MD, MPH, Division of Critical Care Medicine, Children's National Health Systems, 111 Michigan Avenue NW, Washington, DC, 20010, USA; toctober@childrensnational.org; Office phone: 202-476-2070; Office fax: 202-476-5724.

Author Contributions:

Tessie W. October, MD, MPH: Dr. October co-conceptualized and designed the study, assisted with the interpretation of the data, drafted the initial manuscript, approved the final manuscript as submitted, and agreed to be accountable for all aspects of the work.
Zoelle B. Dizon, BA: Ms. Dizon carried out local data collection, assisted with interpretation of the data, critically reviewed and revised the manuscript, approved the final manuscript as submitted, and agreed to be accountable for all aspects of the work.
Melinda F. Hamilton, MD: Dr. Hamilton contributed to the initial study design, critically reviewed and revised the manuscript, approved the final manuscript as submitted, and agreed to be accountable for all aspects of the work.
Vanessa N. Madrigal, MD: Dr. Madrigal contributed to the initial study design, critically reviewed and revised the manuscript, approved the final manuscript as submitted, and agreed to be accountable for all aspects of the work.
Robert M. Arnold, MD: Dr. Arnold co-conceptualized and designed the study, critically reviewed and revised the manuscript, approved the final manuscript as submitted, and agreed to be accountable for all aspects of the work.

Ethics Approval:

This study was approved by the Children's National Health System's Institutional Review Board. Written informed consent was obtained from all participants of the workshop.

Conflicts of Interest

All other authors report no conflicts of interest.

Results—Fifteen clinicians including 8 critical care faculty (80% of eligible participants), 3 subspecialty faculty (100%) and 4 nurse practitioners (100%) participated. Learners' self-reported confidence improved in all communication metrics assessed. Confidence to "give bad news" increased from 39% to 94% post-workshop ($p<0.05$), "conduct a family conference" increased from 50% to 83% ($p<0.05$), and "elicit a family's values/preferences" increased from 39% to 100%. Every learner rated the workshop as important to their clinical practice and 100% would strongly recommend it. All reported the time commitment was not burdensome and 74% would choose this 2-day format over shorter formats.

Discussion—A communication training workshop for inter-specialty clinicians was well received. It is feasible to co-train inter-specialty clinicians in a joint session. When clinicians learn together, they are more likely to speak the same language when communicating with each other and ultimately deliver the same message to families.

Keywords

Interdisciplinary Communication; Critical Care; Medical Education; Simulation training; Child

Introduction

Communication with families is a key element of excellent quality care.^{1,2} In hospitalized settings, multiple clinicians co-manage a patient's care, often communicating with families in silos. Families in the intensive care unit (ICU) report receiving different messages from the clinical team.³ Despite its importance, communication skills curricula are lacking in critical care training. Although there are few trainee-directed communication skills training programs, faculty-directed programs have not been described.^{4,5} Some perceived barriers to clinical faculty training are 1) convincing clinicians the value is worth the time commitment; 2) ability to change behaviors of established clinicians; and 3) lack of available high-impact, high-quality programs.

We developed a 2-day communication skills training workshop for pediatric clinicians, faculty and nurse practitioners (NPs), based on a critical care communication (C3) course.^{6,7} Our modifications targeted tailoring the experience for pediatric clinicians and addressing some perceived educational barriers. The purpose of this paper is to describe an ICU-focused communication skills workshop to teach physicians and NPs the core communication skills needed to co-lead family-centered conferences and assess its feasibility and self-assessed impact. This workshop takes a novel approach to traditional workshops as it is interdisciplinary, with both faculty, defined as attending physicians with academic teaching credentials, and NPs, and inter-specialty within faculty of different disciplines (ICU, neurology, pulmonology) who care for children in the pediatric ICU.

Methods

This faculty-directed workshop was modeled on the C3 course.^{6,7} We made three adaptations for inclusion of faculty from multiple subspecialties and NPs (Figure 1).

Content of Workshop and Cases

The 2-day workshop was divided into three learning activities:

- Didactic (10%) – 20 minute presentation to present evidence supporting communication training and introduce a specific skill.
- Skills demonstration (2%) – 5 minute role play led by the faculty facilitators role-modeling the skills and engaging the audience to identify skills from the didactic exemplified by the faculty facilitator.
- Skills practice (88%) – in small group setting of 4-5 learners, participants practised skills individually with simulated patients and received feedback from the small group and faculty facilitators. We conducted a reflective exercise asking participants to consolidate what they learned and commit to practising different skills at the next session.

Three cases were used, and learners practised skills with simulated patients. Each case was designed for multiple interactions, to better simulate the natural development of relationship-building common in pediatric ICU family conferences. On the first day, the learning goal was to deliver serious news. On day two, learners interacted with the same families with a new skill to practice, such as discussing code status or goals of care.

Participants

Our goal was to enroll all pediatric ICU faculty [n=10 excluding authors (TO, VM)], NPs (n=4), and subspecialists in neurology and pulmonology (n=3) who regularly co-manage patients in our ICU. Participation and evaluation of the workshop was voluntary. Of the 10 eligible ICU faculty, one declined and one had a scheduling conflict, leaving 8 ICU faculty participants. All 4 NPs participated. Two neurologists who exclusively attend in the ICU participated. We routinely have a pediatric pulmonologist who participated. We conducted two sessions, September 2016 and March 2017, to ensure adequate clinical coverage in the ICU as each session was 2-days and off-campus. This study was approved for ethics by our Institutional Review Board. Written informed consent was obtained from all participants for workshop participation and evaluation.

Data collection and analysis

Learners completed pre- and post-workshop surveys designed to assess their self-reported learning goals. The surveys were 5-point Likert scales and included two open-ended questions requesting feedback on improving the course. Learners were also asked to evaluate the course's time commitment.

Our primary outcome was the learner's assessment of skill development. Primary data analysis used descriptive statistics. Paired *t-tests* were used to compare pre- and post-workshop survey responses.

Results

A total of 15 learners completed the workshop (Table 1). Baseline communication education (Table 2) was assessed pre-workshop. Approximately 30% of learners previously received structured teaching (36% faculty, 29% NPs) and half received bedside teaching (52% faculty, 42% NPs) on communication techniques. When learning how to conduct a family conference, most reported they received instruction through bedside teaching (64% faculty, 75% NPs). In general, half never received structured or bedside teaching on communication techniques (56% faculty, 56% NPs).

The learners assessed their confidence with several communication metrics pre- and post-workshop. Post-workshop, there was an increase in self-assessed confidence in all categories (Figure 2). Learner's confidence in "giving bad news" increased from 39% to 94% ($p<0.05$), to "conduct a family conference" increased from 50% to 80% ($p<0.05$), and "discuss various treatment options" increased from 50% to 83% ($p<0.05$). Most notable was the increased confidence to "elicit a family's values and preferences", from 39% to 100%.

Workshop Feedback

All learners rated the workshop as important to developing their skills and 100% would "strongly agree" to recommending it (Table 3). Learners were asked to compare this format with other possibilities. We found learners overwhelmingly (74%) preferred the current 2-day workshop to other less time-consuming options including: online only (0%), 1-day in person + online quarterly (5%), or 1-day in person twice in a year (21%). The learners also reported time commitment was not burdensome given the program's value. Most feedback from the open-ended questions was positive and supported the mix of didactic, skills demonstration, and skills practise. Suggested opportunities for improvement were: 1) including other members of the healthcare team present during family conferences, such as social workers and nurses, 2) more time to practise conflict resolution, and 3) teaching non-verbal communication skills.

Discussion

We developed a communication skills workshop designed to teach core communication skills necessary to co-lead family-centered conferences. Our results confirm clinicians are not receiving structured communication training and learners' confidence with communication skills can be improved in a 2-day workshop.

One of our goals was to assess feasibility of recruiting faculty participants given that trainees' main exposure to communication education is through modeling faculty behavior. We demonstrated busy clinicians were willing and able to participate. By conducting two sessions, we overcame the barrier of providing adequate clinical coverage and gave the learners an experience without interruptions or distractions from clinical demands.

The workshop utilized an evidence-based educational method, including limited didactics, repeated intentional practise with frequent feedback, and interspacing different tasks.⁸ Participants commented on the value of seeing other clinicians speak to patients.

Additionally, they noted skills they would take back to the clinical environment, and were surprised how realistic and emotional the simulated patients and encounters were.

One of the unique features is we invited clinicians who regularly co-lead family conferences to learn and practise together. Having ICU and non-ICU trained clinicians together, we explored inter-team conflict and broke down barriers to open communication. During the reflective exercise, we addressed biases based on discipline and developed a deeper understanding of how we view the same scenario. For example, our sub-specialty faculty admitted they do not always feel the ICU-trained faculty appreciates their long-standing relationships with families. Talking through these emotions and misconceptions, we were able to view the situation from all perspectives and conclude we strive for the same goal: aligning our recommendations with those of the patient and family. Creating an emotionally-safe learning environment is important for sharing ideas, experiences, and emotions.⁹ Seeing other perspectives can only strengthen the inter-team relationship and ensure delivery of one message to the family.

We were not surprised to find, pre-workshop, so few participants had formal communication skills training. Despite the high prevalence of life-limiting illnesses in the ICU and that ICU faculty report talking to families is one of the most stressful parts of their job¹⁰, only 30% had formal training in communication skills. Given this, it was also not surprising their perceived competence was so low. These data support the need for structured training programs, like this workshop, to fill this education gap. It reinforces the need for highly-skilled faculty well-trained in communication because role-modeling continues to dominate the type of communication skills education for trainees.

We believe the novelty of this teaching approach is breaking down the silos of clinical medicine. Other workshops in the literature focus on individual groups and do not cross into different specialties and disciplines learning together. Clinically, we co-manage patients, but the ability to communicate with each other and communicate the same message to families is dependent on clinicians speaking the same language. We aim to expand this workshop to a larger group of learners, including clinical trainees and other clinicians who participate in family conferences.

While demonstrating these strengths, we also acknowledge some limitations: (1) this was trialed at a single institution; (2) we enrolled a small number of learners to maximize small group experiential learning; (3) other clinical team members, such as nurses and social workers, did not participate; (4) and we did not evaluate the impact of the course on healthcare behaviors or outcomes.

Conclusion

An inter-specialty communication workshop for clinicians is feasible and learners report it was successful in improving their communication skills to co-lead family conferences. Developing interdisciplinary and inter-specialty workshops for faculty clinicians may result in improved relations between subspecialists who co-manage patients. Families deserve to hear a unified message when caring for a critically ill child. By facilitating clinicians'

working together, the clinical teacher of critical care is one step closer to providing families with the information needed to make critical decisions.

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Pull out quotes

1. When clinicians learn together, they are more likely to speak the same language when communicating with each other and ultimately deliver the same message to families.
2. The purpose of this paper is to describe an ICU-focused communication skills workshop to teach physicians and NPs the core communication skills needed to co-lead family-centered conferences.
3. Our results confirm clinicians are not receiving structured communication training and learners' confidence with communication skills can be improved in a 2-day workshop.
4. Having ICU and non-ICU trained clinicians together, we explored inter-team conflict and broke down barriers to open communication.
5. These data support the need for structured training programs, like this workshop, to fill this education gap.
6. Clinically we co-manage patients, but the ability to communicate with each other and communicate the same message to families is dependent on clinicians speaking the same language.
7. By learning together, the clinical teacher of critical care is one step closer to providing families with the information needed to make critical decisions.

Communication Workshop Adaptations based on the Original C3 Course

Figure 1.
Communication Workshop Adaptations

Figure 2.
Learner's Confidence with Communication Skills: Pre- and Post-workshop
Self-Assessed Score of "4, Confident" and "5, Very Confident"

Table 1**Learner Demographics**

ICU Faculty	n=8 (%)
Sex, female	6 (75)
Ethnicity	
Caucasian	6 (75)
East Indian/Pakistani	2 (25)
Number of Family Conferences Led	
<5	2 (25)
6-10	0 (0)
>10	6 (75)
Number of Years of Faculty Practice	
5 years	3 (37)
>5 years	5 (63)
Subspecialty Faculty	n=3 (%)
Sex, female	3 (100)
Ethnicity	
Caucasian	1 (33)
African American	1 (33)
Hispanic/Latino	1 (33)
Number of Family Conferences Led	
<5	1 (33)
6-10	0 (0)
>10	2 (66)
Number of Years of Faculty Practice	
5 years	1 (33)
>5 years	2 (66)
Nurse Practitioners	n=4 (%)
Sex, female	4 (100)
Ethnicity	
Caucasian	3 (75)
African American	1 (25)
Number of Family Conferences Led	
<5	3 (75)
6-10	1 (25)
>10	0 (0)
Number of Years of Nurse Practitioner Practice	
5 years	2 (50)
>5 years	2 (50)

Table 2

Learner Baseline Communication Education

During my medical/nursing training, I received instruction on the following topics:	Faculty n=11 (%)		Nurse Practitioners n=4 (%)	
	Structured Teaching	Bedside Teaching	Structured Teaching	Bedside Teaching
Giving bad news to a family about their child's illness.	6 (55)	6 (55)	2 (50)	1 (25)
Conducting a family conference.	4 (36)	7 (64)	2 (50)	3 (75)
Discussing various treatment options, including palliative care, with families of critically ill patients.	4 (36)	5 (45)	1 (25)	2 (50)
Discussing the withdrawal of intensive care treatments.	4 (36)	6 (55)	0 (0)	1 (25)
Discussing code status (Do Not Resuscitate) with a family member.	3 (27)	5 (45)	1 (25)	1 (25)
Eliciting a family's values and preferences around treatment decisions.	3 (27)	5 (45)	1 (25)	2 (50)

Table 3

Learner Feedback on the Workshop Curriculum

Workshop Curriculum	Likert Scale n (%)			
	Poor	Fair	Good	Very Good
Relevance to your practice	-	-	-	-
Usefulness of didactic sessions	-	-	2 (13)	4 (27)
Usefulness of skills demonstration	-	1 (7)	-	2 (13)
Usefulness of skills practice	-	1 (7)	-	3 (20)
Usefulness of reflective exercises	-	1 (7)	-	-
Usefulness of simulated patients	-	-	-	-
Overall educational quality	-	1 (7)	-	-