

Direct Trainee Observation: Opportunities for Enhanced Physician–Patient Communication and Faculty Development

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The art of effective interviewing and communication skills has dwindled despite the fact that these skills are among the most critical elements of an effective physician–patient relationship (PPR). Enhanced PPR leads to a reduction in physician burnout,

malpractice suits, and healthcare costs, meanwhile heightening the capacity to fully understand the patient's illness and concerns, which may be reflected in widely visible patient satisfaction web sites. Increasing patient volumes, perceived attitudes toward particular diagnoses, and insufficient attention by regulatory bodies in charge of education and training has limited professional growth in this critical area. The complex, multidimensional nature of gastrointestinal (GI) presentations, increase in the number of comorbid conditions, and change in accountability in clinical practice has reenergized the discussion for providing efficient, high-quality care. Training at all levels, from the first-year medical student to an established faculty member or community practitioner, is critical in successful implementation of effective communication skills, which can lead to an effective PPR. This is important across all medical specialties, but more so in subspecialties such as gastroenterology and hepatology, fields where communication is of vital importance owing to complex clinical presentations, and higher frequency of functional disorders, invasive testing, and management plans.

The Accreditation Council for Graduate Medical Education (ACGME) released revised common program requirements that went into effect on July 1, 2012.¹ These guidelines recommend using graduated levels of supervision with direct, indirect, and oversight strategies. The new requirements specifically ask for fellow assessment in data gathering, clinical reasoning, and patient management skills using direct observation of patient encoun-

ters. Along with other internal medicine subspecialties, gastroenterology and advanced hepatology training programs have or are in the process of adopting different physical mechanisms for conducting direct observation in the outpatient setting, including the use of cameras, 1-way mirrors, or in-room observation. These new requirements create unique opportunities for improving physician communication skills, faculty development on how to give meaningful feedback, and research in physician–patient interactions. With the Next Accreditation System, trainee performance will be assessed using outcomes-based milestones within the 6 clinical competencies; regardless of specialty, this will require increased direct observation of the learner.

Examples of Barriers in Communication Skills in Gastroenterology

The vital importance of effective communication skills can be appreciated across the spectrum of GI and liver disorders. In an educational-need assessment study among gastroenterologists caring for inflammatory bowel disease (IBD) patients, ineffective communication among healthcare team members and with patients was perceived as an important barrier to patient education, treatment compliance, and overall clinical care.² Additionally, discordant PPR is a known factor for nonadherence to IBD therapy.³ Patients with celiac disease have been found to have negative attitude toward their disease with unsatisfactory counseling from the physician caring for them.⁴ Patients with irritable bowel syndrome have rated the qualities of “being heard” and “receiving empathy” from a physician as being more important than ordering additional tests, and this discrepancy in goal setting has led to perceived negative relationships with their healthcare providers.^{5,6} Difficult clinical encounters can also contribute to provider fatigue and frustration.⁷

As additional examples, 41% of patients with hepatitis C reported interpersonal challenges with their physicians, namely owing to poor physician communication, stigma related to their disease, or a sense of abandonment by

their physicians.⁸ Related to endoscopy, patients perceive communication with the ordering and performing physician as an important endoscopic quality measure,⁹ and the geriatric patient population was found to be more vulnerable to suboptimal communication during endoscopic procedures.¹⁰ Overall, there are enough data to support that communication skills do impact patient satisfaction, treatment adherence, and other aspects of clinical outcomes within gastroenterology and hepatology.¹¹

Current State of Training in Communication Skills

Trainee Perspective

The ACGME recommends assessment in 6 core competencies: Patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication (IPC) skills, professionalism, and systems-based practice. Of these, IPC skills can be indirectly assessed by trainees' interaction with members of the healthcare team, patient interactions during the informed consent process for endoscopy, and feedback provided by patients themselves. However, there is currently no widespread, systematic way of evaluating and providing feedback on these skills. Existing mechanisms where trainees receive feedback on their IPC skills include multisource evaluations by peers, patients, nurses, clinical assistants, and faculty. However, none of these processes ensure that the trainee receives real-time constructive feedback on a case-by-case basis with specific concepts to improve upon. A formative assessment at the end of the rotation is one such method to deliver face-to-face feedback, but multiple barriers prevent this from being as meaningful, including the need for dedicated time to give feedback, lack of faculty development on how to give behavioral and criterion-based feedback, and the timing of feedback as it relates to specific clinical encounters. It is also not uncommon to see a trainee who performs well during interactions with the healthcare team but suboptimally during patient interactions. In a nationwide survey of internal medicine residency programs, and supported by additional studies, the use of direct observation is infrequent.¹² A meta-analysis has shown that teaching patient communication skills to medical students using either small group discussions or through feedback on a student-patient interview results in improvement in student performance.¹³ Inadequate clinical supervision and feedback on performance have been linked with negative ratings by trainees of their program and faculty.¹⁴ In general, constructive and timely feedback is viewed as positive and useful by trainees.

Faculty Perspective

Faculty perceive that feedback can be an effective learning tool for trainees. However, the ability of faculty to provide specific feedback, especially if negative, may vary and is often limited. Considering the lack of standardized training at the faculty level, the feedback process becomes subjected to personal behavior and biases. Multiple factors can significantly impact the feedback process, such as faculty skills in balancing positive and negative feedback, perceived self-inefficacy, and perceptions of the trainees' insight, receptivity, skill, and potential.¹⁵ Effective faculty development regarding the feedback process is critical to the success of a direct observation program.¹⁶ As a result, the ACGME now requires key clinical faculty to participate in faculty development aimed to enhance the effectiveness of their teaching. Some have recommended the use of Objective Structured Clinical Encounters in training programs to enhance communication skills during challenging clinical encounters and facilitate practice-based learning and improvement.¹⁷ Similarly, standardized patient exercises have also been proposed to enhance faculty evaluation skills.¹⁸ Overall, it should be acknowledged that faculty development is a critical unmet need in this area, and how to give feedback during direct observation can be an area of focus in future "train-the-trainer" models.

Tools for Direct Observation

Although a number of instruments have been identified for direct observation of clinical skills, their validity and impact on educational outcomes is unclear.¹⁹ The American Board of Internal Medicine's Clinical Supervision-Practice Improvement Module (CS-PIM) was rated highly by faculty for improving their documentation of the feedback process, reflecting on summary reports, developing an improvement plan, and self-assessment of supervisory skills. The CS-PIM involves observing and documenting trainee-patient clinical encounters using the mini-Clinical Evaluation Exercise model, auditing the associated medical record for quality, internal consistency, and patient safety measures, and creating a self-improvement plan. Faculty reported improved skills at auditing medical records and identifying errors,²⁰ which is a needed area of enhancement given the majority of trainees report feedback on their documentation <50% of the time.²¹ In addition to enhancing their own skills, faculty can claim maintenance of certification credit by completing 10 assessment cycles. Recently, a modified version of the Structured Clinical Observation was found to increase the frequency of feedback provided, and its use resulted in more feedback on listening skills and less feedback on medical knowledge.²² In this process, a faculty member directly observes behavior for 3- to 5-minute periods intermittently during the clinical

Table 1. Key Elements of Physician–Patient Communication Skills

Setting the stage
Ensure that environment is quiet, private, and nonthreatening.
Exchange a handshake (or another culturally appropriate greeting) and address the patient formally.
Establish eye contact by sitting at the patient's level.
Brief social chatter can help the patient to relax, build rapport, and be a source of social conversation for future visits.
Minimize looking at the electronic medical record early in the conversation.
Minimize distractions (eg, pager replies, cell phone).
The “biopsychosocial” interview
Identify the key problem and set an agenda. Respectfully defer problems that are outside of your specialty or those you cannot address owing to time limitations.
Provide a few minutes of open-ended discussion for the patient to present the problem (which can often differ from the original referring indication). Listen actively.
Inquire about the emotional and social impact of the medical condition on the patient and family.
Focus on nonverbal cues
Nonverbal patient behaviors (eg, gestures, agitation, smiles, frowns, and tears) can be apparent before the interview starts and throughout the clinical encounter.
Physician behaviors (eg, body language, voice tone, and mannerisms) can affect patient perception.
Identify signs of patient uncertainty, especially during discussion of complicated management plans, and offer clarification when needed.
Closure
Elicit feedback on the information provided, ensure understanding, and ask for any concerns.
Validate patient's feeling and offer empathy.
Help the patient take responsibility.
Ensure your availability if subsequent questions or concerns arise.

encounter and provides feedback to the trainee about the behaviors observed. A training program can adopt a tool most suited for their faculty; however, use of a validated or widely endorsed tool will allow standardization, comparison across programs and the ability to provide maintenance of certification credits.²³

Key Concepts in Physician–Patient Communication Skills

A comprehensive overview of physician–patient communication skills is beyond the scope of this piece and can be found elsewhere.^{11,24} Certain examples of ineffective and effective patient–provider discussion can be reviewed²⁵; key concepts are summarized in Table 1. Skills in building rapport, setting an up-front agenda, and acknowledging social or emotional cues have all been linked with increased efficiency in clinical encounters.²⁶ A meta-analysis found that nonverbal communication measures, such as clinician warmth (as measured by ratings of caring or sensitivity) and active listening, improve patient satisfaction.²⁷ In this context, one has to be sensitive about differ-

ences in gender, culture, and literacy level. The clinical encounter style also needs to be modified according the type of encounter (new vs established patient), reason for encounter (discussion of clinical symptoms vs a terminal diagnosis), and the presence or absence of a family member or interpreter. The American Gastroenterological Association and Rome Foundation partnered on a communication, skills workshop and additional videos reflecting critical concepts of enhancing communication skills using facilitated role play can be reviewed.^{28,29}

Opportunities for Faculty Development

The American Board of Internal Medicine's direct observation CS-PIM has been shown to improve faculty's ability to assess trainee communication skills, provide feedback, and self-reflect on personal skills. More widespread use of such a tool can guide faculty to areas where they most need to enhance their own skills, thereby improving communication skills at all levels. A Cochrane review recently showed that training of healthcare providers in promoting patient-centered care is effective, and short-term training (10 hours) is as effective as longer training sessions.³⁰ Overall, faculty training in how to assess communication skills and provide feedback to trainees is as important as their training in any other domain, and direct observation should be seen as a potent tool to strengthen this skill set.

Opportunities for Research

A number of instruments for assessing PPR exist, measuring diverse dimensions and conceptual models of the relationship.³¹ Future research can utilize direct patient observation as a means to test and validate some of these instruments. Direct trainee observation can also allow a supervising faculty member to better understand the patient's role and involvement in the clinical encounter. Patients may engage in clinical encounters to varying degrees, which may impact the shared decision making process; direct observation can serve as a tool to further advance science in that area.³² Additionally, discussion of rapidly emerging therapies for diseases such as IBD and viral hepatitis require an enduring PPR and an ability to deliver a message of risks, benefits, and alternatives in a way that is tailored to each individual patient's needs. Research on the best ways to improve dialogue with patients will ultimately help in patient engagement and compliance with treatment, and assessing these skills and best practices early in training is paramount. Societal initiatives such as those by the AGA, the American Academy on Communication and Health Care, and the Rome Foundation can further enhance research, education, and delivery of enhanced communication skills. Table 2 summarizes concepts for trainee education in communication skills.

Table 2. Concepts for Trainee Education in Communication Skills

Start by asking the trainee what he/she felt went well, and begin the feedback session affirming the positives
Next, ask what areas the trainee struggled with the most, and where he/she felt the deficiencies were.
Provide concrete examples of observed deficiencies in communication, possible reasons for them, and the consequences for patients and doctors.
Offer an evidence-based approach for the skills needed to overcome these deficiencies.
Demonstrate the skills to be learned by the trainee and elicit reactions to these.
Provide an opportunity to practice the skills under controlled and safe conditions.
Give constructive feedback on performance as it progresses, and reflect on reasons for any blocking behavior continually observed.

NOTE. Modified from Maguire P, Pitceathly C. Key communication skills and how to acquire them. *BMJ* 2002;325:697–700. Reproduced with permission from BMJ Publishing Group, Ltd.

Concluding Remarks

A number of strategies can be utilized for assessing and teaching communication skills of trainees, including direct observation, videotaping preceptor and learner interactions, small group discussion, individual or group role play, simulated patients, and direct training sessions. Direct observation is among the easiest and most commonly practiced techniques and will be required for all ACGME-affiliated training programs to implement into the curriculum. This provides an unparalleled opportunity for trainees to work on building physician-patient communication skills and for faculty to gain added experience in providing direct and meaningful feedback. Finally, it is a great area for research for clinician educators to become involved to systematically study concepts around physician-patient communication and the feedback process. An effort like this from the ACGME is a welcomed step, and is envisioned to ultimately enhance the practice of medicine in these challenging times.

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Conflicts of interest

The authors disclose no conflicts.