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A rigorous evaluation of an institutionally-based communication skills program for post-graduate oncology trainees

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ABSTRACT

Objective: Integrating education about physician–patient communication into oncology specialists' education is important to improve quality of care. Our aim was to rigorously evaluate a 4-year institutionally-based patient communication skills program for oncology post-graduate trainees.

Methods: Trainees from 10 specialties in the U.S. participated in patient communication skills modules tailored to sub-specialties. The program was evaluated by comparing pre-post scores on hierarchical outcomes: course evaluation, self-confidence, skills uptake in standardized and real patient encounters, and patient evaluations of satisfaction with communication. We examined breadth of skill usage as key outcome. Generalized estimating equations were used in data analysis.

Results: Two hundred and sixty-two trainees' data were analyzed, resulting in 984 standardized and 753 real patient encounters. Participants reported high satisfaction and demonstrated significant skill growth with standardized patients, but transfer of these skills into real patient encounters was incomplete. Participants with lower baseline scores had larger improvements with both standardized and real patients.

Conclusion: The program was well received and increased participant skills in the simulated setting without effective transfer to real patient encounters.

Practice Implications: Future work should allocate proportionally greater resources to trainees with lower baseline scores and measure breadth of participant skill usage as an outcome.

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1. Introduction

Physician–patient communication is an essential component of medical education because of its impact on patient and physician outcomes [1–3]. Particular emphasis has been given to improving cancer communication due to the complex, challenging nature of cancer care [4]. Such programs have been developed, implemented, and evaluated internationally (e.g. [5–8]).

Post-graduate oncology trainees may have a particular need for communication courses due to stresses associated with being an inexperienced physician [8]. The first U.S. federally funded

program to target this group was *Oncotalk*, which focused on communicating with patients who have incurable or progressive cancer [9]. Oncology trainees from 62 institutions participated in a 4-day retreat and demonstrated improved communication skills with standardized patients (SPs) [10].

We hypothesized there would be advantages to a physician–patient communication skills program implemented for all post-graduate oncology trainee physicians (i.e., residents and fellows) *within* an institution rather than a group gathered from multiple locations. First, an institutionally-based program is better able to attend to the *hidden curriculum*, the implicit learning that happens through role modeling and transmission of cultural norms [11]. Second, it allows for measurement of trainee behavior change during regular clinical practice. Third, it allows for tailoring for subspecialties based on input from medical education leadership.

The aim of this study was to rigorously evaluate an institutionally-based physician–patient communication skills program for oncology post-graduate trainees. Our research questions were:

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RQ 1: Is there a main effect of the program on self-confidence, skills uptake with SPs and real patients, and patient evaluations?

RQ 2: What characteristics predict the magnitude of change (pre-training to post-training) in communication skills and patient evaluations?

2. Methods

2.1. Study design

The study design was a pre-post single arm intervention. Our evaluation model (Fig. 1) was a version of Kirkpatrick's assessment model modified for communication skills education [4,12,13]. The model describes four levels of assessment, with progressively complex behavior change. Level 1 assesses participants' *reaction* to the program, which we measured through course evaluations. Levels 2A and 2B assess *learning* measured through self-reports and Standardized Patient Assessments (SPAs). Level 3 assesses change in *behavior*, which we measured through recording and coding real patient interactions. Level 4 assesses the *results* of the program, measured through patient surveys in our study.

To attain the most complete evaluation, assessment should be multi-methodological, utilizing all levels. However, as the main purpose of our study was to examine the impact on trainee behavior and on patient evaluations (Levels 2B, 3 and 4), we primarily focused on these levels.

2.2. Participants

2.2.1. Trainees

Trainees from 10 specialties at Memorial Sloan Kettering Cancer Center (New York City, U.S.) participated in a physician-patient communication skills program across four academic years (2010–14), as part of their training. All trainees at our institution whose program directors had chosen to be part of the program were included. There were no trainee exclusion criteria. Trainees gave permission to use their data for research purposes. The study was approved by the institution's IRB.

2.2.2. Patients

A research study assistant screened patients for eligibility and approached them for consent. Patient inclusion criteria included the ability to provide informed consent and to speak and read

English. For Pediatric and Critical Care trainees, legally authorized representatives (LARs) could participate instead of the patient as appropriate.

2.3. Intervention

The Comskil Model, a skills-based approach to teaching communication skills in a cancer setting, guided the program [4,14–16]. This approach promotes a patient-centered approach and tailoring communication to patients' individual needs. We followed internationally accepted best practices for the method of teaching communication [17]. Each module was approximately 2 h, included a short lecture, and demonstration videos, with the majority of the time spent in facilitator-led small group role play.

Trainees participated in either four or six modules according to specialty (Table 1). To help address the hidden curriculum, multi-disciplinary faculty members co-led the small group role play sessions. In order to participate as a facilitator, they completed the six-module course as a participant and subsequently completed a facilitator course [4,18]. By completing the course as a participant, the faculty members became familiar with the curriculum and were able to critically evaluate their own communication skills and improve their own practice of communication skills in the hospital. We assessed fidelity by coding for adherence to our facilitation model [19].

2.4. Assessment procedures

Our assessment procedures are described in Fig. 2 as they occurred chronologically. Here we describe the procedures for each outcome.

2.4.1. Course evaluations (level 1) and self-confidence (level 2A)

At the end of each module, trainees completed an anonymous questionnaire evaluating the module and assessing their own confidence about the content.

2.4.2. Skills application with SPAs (level 2B)

Immediately before the course, trainees completed two (early/advanced disease) 12-minute video recorded SPAs with trained SPs. We audited 25% of SPAs and gave feedback to SPs who were not performing up to standard. Over the four years, the average SP adherence ranged from 82.8% to 89.7%. Immediately following the

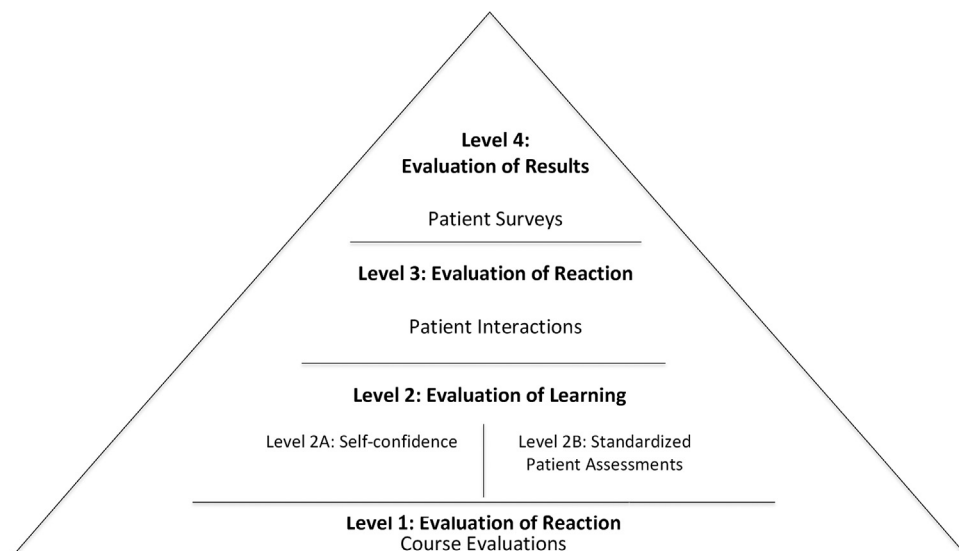


Fig. 1. Application of Kirkpatrick's Evaluation Model to the Communication Skills Program.

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