Improving Communication Skills: A Course for Academic Medical Center Surgery Residents and Faculty

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OBJECTIVE: To improve physician/patient communication and familiarize surgeons with contemporary skills for and metrics assessing communication, courses were developed to provide academic general surgery residents and faculty with a toolkit of information, behaviors, and specific techniques. If academic faculty are expected to mentor residents in communication and residents are expected to learn good communication skills, then both should have the necessary education to accomplish such a goal.

DESIGN: Didactic lectures introduced current concepts of physician-patient communication including information on better patient care, fewer malpractice suits, and the move toward transparency of communication metrics. Next, course participants viewed and critiqued "Surgi-Drama" videos, with actors simulating "before" and "after" physician-patient communication scenarios. Finally, participants were provided with a "toolkit" of techniques for improving physician-patient communication including "2–3–4"—a semiscripted short communication tool residents and other physicians can use in patient encounters—and a number of other acronymic approaches.

RESULTS: Each participant was asked to complete an anonymous evaluation to assess course content satisfaction. Overall, 86% of residents participated (68/79), with a 52% response rate (35/68) for the evaluation tool. Overall, 88% of faculty participated (84/96), with an 84% response rate (71/84). Residents voiced satisfaction with all domains. For faculty, satisfaction was quantitatively confirmed (Likert score 4 or 5) in 4 of 7 domains, with the highest satisfaction in "communication of goals" and "understanding of the HCAHPS metric." The percentage of "top box" Doctor Communication Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and national percentile ranking showed a sustained increase more than 1 and 2 years from the dates of the courses.

CONCLUSIONS: The assessment of communication skills is increasing in importance in the practice of surgery. A course in communication, as developed here, quantitatively confirms the effectiveness of this approach to teaching communication skills as well as identifying areas for improvement. Such a course was part of a plan to increase the percentage of "top box" HCAHPS scores and percentile rankings. Faculty can impart the skills gained from such a course to residents attempting to successfully navigate the Accreditation Council for Graduate Medical Education (ACGME) Milestones and future careers as practicing surgeons. (J Surg 72:e202-e211. © 2015 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: ACGME milestones, physician-patient communication

COMPETENCIES: Patient Care, Medical Knowledge, Professionalism, Interpersonal and Communication Skills

INTRODUCTION

Physician-patient communication plays a critical role in the education of and motivation for patients to assist in shared decision making.[1] From an historical perspective, physicians honed their own, immutable style for communication skills at the bedside. These "soft" communication skills were presumably learned through observing the "bedside manner" while rounding at the feet of master clinicians.[2] From a contemporary perspective, communication skills are a set of modifiable behaviors that can be objectively assessed as a core competency.[3-5] Academic medical centers tend to be quaternary care environments with multiple physicians interacting with seriously ill patients, often far from family and friends, and thus, they have unique communication challenges. However, the skills required for effective medical

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communications are not innate and must be learned and reinforced through practice.[6] Good communication skills are also necessary for communication among physicians, between physicians and the public, and where physicians speak with media outlets, but physician-patient communication forms the basis for improving patient care. Physician-patient communication skills are thus a core competency for surgeons and surgery residents.

A course was developed to provide academic medical center surgery faculty, and separately residents, with a toolkit of information, behaviors, and specific techniques designed to enhance awareness of and improvements in communication skills. Firstly, a didactic lecture introduced current concepts of physician-patient communication including, among other topics, a description of the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) Doctor Communication scores. Individual physician metrics were provided to each faculty participant to make the concepts "stickier." Secondly, HCAHPS "hot comments" were used in preparation of scripted "Surgi-Drama" videos, with actors simulating "before" and "after" physician-patient communication. Thirdly, course faculty encouraged resident and faculty participants to critique the video segments. Finally, course participants were provided with a "toolkit" of techniques for improving physician-patient communication including "2–3–4"—a semiscripted short communication tool residents and other physicians can use in patient encounters—and a number of other acronymic approaches.

METHODS

Course Development and Organization

The course was organized into 4 parts. Firstly, faculty received a didactic introduction to current concepts of physician-patient communication. In response to the enthusiastic reception of an initial course for surgical faculty, residents requested a similar course pitched at their level with a focus on concerns in the inpatient setting. In the course, 3 concepts were emphasized, including the role of good communication in improving patient care and better outcome metrics. The link between good communication and fewer malpractice lawsuits was also discussed.[7] Poor communication can be a source of patient dissatisfaction, which is a harbinger of legal action.[8] Communication plays an important role in malpractice claim and patient complaint data; provider behavior accounted for 19% of complaints in a patient complaints system, second only to communication.[9] CAHPS Hospital and Clinician Group Doctor Communication scores are measures of inpatient and outpatient communication, respectively. These measures were emphasized given the current mania for transparency, the anticipated public reporting of such measures, and their inclusion in Centers for Medicare & Medicaid Services value-based purchasing and other third party pay for performance schemes.[10,11] Although not currently measured, introduction of such data was provided to the residents, given the effect of such public reporting on their future careers as surgeons regardless of type of practice.

TABLE 1. HCAHPS "Hot Comment" Themes

1. Communication—care management (status updates, plan of care, and transitions)
2. Dismissed concerns/compassion (did not listen to patient concerns, ignored, rough, and not sensitive to situation)
3. Limited time with physician (not seeing attending physician postoperatively or minimal time throughout stay)
4. Rushed encounter with physician
5. Wait time (MD discharge orders holding up discharge, tests, OR delays, and procedure)

OR, operating room.

Secondly, HCAHPS "hot comments"—handwritten survey responses from actual Department of Surgery patient-returned surveys—were reviewed and categorized based on underlying themes (Table 1). The "hot comment" themes were incorporated into the Surgi-Drama scripts that formed a part of the courses for faculty and residents (Appendices 1 and 2). Faculty and residents viewed "Surgi-Dramas," or scripted videos, with actors simulating a "before" and "after" physician-patient communication scenario. Faculty and residents viewed videos specifically tailored to their level of training. Thirdly, course facilitators encouraged participating faculty or residents to critique the first video segments representing poor communication skills. Finally, participants were provided with a "toolkit" of techniques for improving physician-patient communication. The "toolkit" was based on a variety of acronymic aids to assist in better communication with patients, and "2–3–4," an easy-to-remember semiscripted technique for residents to use at each patient bedside encounter, was also provided for the residents.

Data Analysis

Surveys were distributed to course participants in an attempt to ascertain which ideas were considered valuable. There were 6 questions with responses on a 5-point Likert scale, with anchors from "strongly disagree" (1) to "strongly agree" (5).[12-14] The individual data sheets were summed, and satisfactory scores were considered to be a 4 or 5. Open-ended questions soliciting information about the strengths and opportunities to improve the courses were also asked.

The Department of Surgery HCAHPS data were taken directly off the Penn Quality Data Mart. For faculty, individual provider-specific data were also generated from the Penn Quality Data Mart. The data were provided in a

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