Simulated Disclosure of a Medical Error by Residents: Development of a Course in Specific Communication Skills

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OBJECTIVES: Surgery residents are expected to demonstrate the ability to communicate with patients, families, and the public in a wide array of settings on a wide variety of issues. One important setting in which residents may be required to communicate with patients is in the disclosure of medical error. This article details one approach to developing a course in the disclosure of medical errors by residents.

DESIGN: Before the development of this course, residents had no education in the skills necessary to disclose medical errors to patients. Residents viewed a Web-based video didactic session and associated slide deck and then were filmed disclosing a wrong-site surgery to a standardized patient (SP). The filmed encounter was reviewed by faculty, who then along with the SP scored each encounter (5-point Likert scale) over 10 domains of physician-patient communication. The residents received individualized written critique, the numerical analysis of their individual scenario, and an opportunity to provide feedback over a number of domains. A mean score of 4.00 or greater was considered satisfactory. Faculty and SP assessments were compared with Student *t* test.

SETTING: Residents were filmed in a one-on-one scenario in which they had to disclose a wrong-site surgery to a SP in a Simulation Center.

PARTICIPANTS: A total of 12 residents, shortly to enter the clinical postgraduate year 4, were invited to participate, as they will assume service leadership roles. All were finishing their laboratory experiences, and all accepted the invitation.

RESULTS: Residents demonstrated satisfactory competence in 4 of the 10 domains assessed by the course faculty. There were significant differences in the perceptions of the faculty and SP in 5 domains. The residents found this didactic, simulated experience of value (Likert score ≥ 4 in 5 of 7 domains assessed in a feedback tool). Qualitative feedback from the residents confirmed the realistic feel of the encounter and other impressions.

CONCLUSIONS: We were able to quantitatively demonstrate both competency and opportunities for improvement across a wide range of domains of interpersonal and communication skills. Residents are expected to communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds. As academic surgeons, we must be mindful of our roles as teachers, mentors, and coaches by teaching good communication skills to our residents. Courses such as the one described here can help in improving physician-patient communication. The differing perspectives of faculty and SPs regarding resident performance warrants further study. (J Surg 71:e116-e126. © 2014 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: ACGME core competencies, apology, disclosure of adverse outcomes, physician-patient communication

COMPETENCIES: Professionalism, Interpersonal and Communication Skills, Systems-Based Practice

INTRODUCTION

External pressures for the disclosure of adverse outcomes have been increasing for some time.[1] Educating residents in disclosure of adverse outcomes is particularly difficult; these conversations are sensitive, require a particular communication skill set, and may be conducted in the setting of considerable emotional distress.[2,3] The Accreditation Council for Graduate Medical Education has, among other core competencies, mandated the development of interpersonal and communication skills; residents must acquire

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interpersonal and communication skills for exchanging information effectively with patients and families.[4] At academic medical centers, residents frequently care for patients who have sustained adverse outcomes.[5,6] Despite the importance of this topic, only a minority of trainees receive training in error disclosure.[7] Few doctors in training receive feedback about disclosure skills or know how to access institutional resources for support after making an error.[8] The lack of formal training has led some commentators to conclude that trainees may not be prepared to disclose medical errors, create a worrisome trend in how apologies are made, and enhance individual and institutional liability.[9] Therefore, it is critical for physicians—including residents—who are disclosing adverse outcomes to know how to conduct themselves.

As a means of educating residents in communicating adverse outcomes, 12 residents, shortly to enter the clinical postgraduate year 4, were invited to participate in a course on how to disclose medical error. All were finishing their laboratory experiences, and all accepted the invitation.

METHODS

The University of Pennsylvania surgery residency communication course incorporated principles of etiquette-based communication, a series of behaviors designed to enhance physician-patient communication.[10] The course was also loosely based on a course in the disclosure of adverse outcomes developed by James W. Pichert and Gerald B. Hickson of the Vanderbilt University Center for Patient and Professional Advocacy, a course in which the faculty reviewer had participated.[11] Individuals invited to undergo training were introduced to the basics of adverse event disclosure first through a Web-based didactic session and associated slide deck. Once the didactic materials were reviewed, the residents participated in a disclosure scenario. The scenario included the obvious injury, obvious error problem of a wrong-site surgical procedure (Appendix 1).[12] The scenario was realized using standardized patients (SPs) and residents were filmed disclosing the wrong-site error to the SP. The filmed encounter was reviewed and scored by faculty who had previously participated in the Vanderbilt Center for Patient and Professional Advocacy course. The review included numerical scoring according to an assessment tool used by both faculty and SP; aspects of the assessment tool used by both the faculty and the SP were adapted in part from a previous report (Appendix 2).[13] The score sheet used a Likert scale with 5 anchors: inappropriate, minimally appropriate, somewhat appropriate, substantially appropriate, and completely appropriate.[14-16] The optimal number of Likert-type scale response alternatives has been well researched, and for this study, 5 appeared adequate for discrimination purposes.[17-21] The analysis included 10 domains assessing a variety of communication elements including the providers' ability to use effective communication strategies with a focus on the providers' ability to engage in open-ended questioning, respond to emotions, convey sympathy, relay medical information, and convey commitment to well-being. In addition, each resident was asked to provide anonymous feedback intended to improve the course for future course participants and to review their individual filmed scenario. Each resident received feedback in the form of an individualized written critique.

This course was attended by senior-level residents (entering the postgraduate 4 clinical year), about to embark on the senior clinical phase of their residency, when their supervisory position might require the use of such disclosure skills. As residents with some autonomy and decision-making responsibility, it is likely they will be involved in caring for patients with medical injuries that are ultimately the responsibility of the attending surgeon. Arguably, all residents should learn truth telling from day 1 of residency, but there is little published literature on how to teach this skill. Using an evaluation tool, the residents were able to provide anonymous feedback to the course organizers (Appendix 3).

This was intended to be an intentionally difficult scenario. The events are necessarily contrived, but one of the paramount issues residents should consider as they finish the clinical residency is to take universal precautions against making a wrong-site procedure seriously. Although letting a wrong-site procedure to happen is generally considered a "systems error" for the health care organization and those involved, the one holding the knife will most directly shoulder the consequences. The scenario was developed, and SPs were briefed in advance for the role. Scheduling concerns led to the inability to use the same actor in all scenarios for resident participants. When the scenario was written, there were approximately 20 responses the actor could use depending on the resident's initial comments. The impression of the SPs and faculty was that the residents were interacting as if it were essentially a real encounter, a fact echoed by some of the written feedback of the residents. The scenario was designed for wrong-site surgery and is considered an "obvious/obvious," which means obvious error causing an obvious injury.[12] The intent was that the attending surgeon was not present for the wrong-site incision, and it was assumed that a properly experienced resident was responsible for the actual incision. In this scenario, the attending surgeon first had a meeting with the patient to disclose the obvious fact that the wrong side was incised. However, the resident was not present, so he or she did not know what was said by the attending surgeon.

Statistical Analysis

For each of the 10 domains of communication, the mean, median, and mode were calculated. Faculty and SP scores