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An interprofessional pilot program training medical residents in trauma-sensitive communication

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ABSTRACT

This pilot project tested a brief interdisciplinary intervention to enhance trauma-sensitive communication skills among medical residents who provide care to female veterans. While guidelines exist on providing "trauma-sensitive care", one challenge is translating these principles into practice through education and training. The target audience was medical residents (PGY1-PGY3; n = 8), who were observed 3 times by a clinical psychologist during their women's primary care clinic rotation at a VA hospital. The intervention format entailed the psychologist providing individualized feedback on basic interpersonal communication and trauma-sensitive care. Residents completed a pre- and post-intervention survey regarding their skill, comfort, perceived use of patient-centered approaches, and their understanding of trauma-sensitive care. The post-intervention survey included an intervention feedback section.

Results indicated improvements in resident self-perceived communication skills and greater comfort discussing and responding to trauma disclosure. Qualitative feedback indicates residents found the training useful. This novel pilot study shows the promise of a brief interprofessional intervention for improving communication skills in behavioral health among medical residents, particularly regarding trauma. Next steps include testing with a larger sample in a randomized controlled trial, and examining effects of training on patient satisfaction.

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1. Format

A clinical psychologist familiar with the clinic and female veteran population provided "in-vivo" observation of patient interviews during medical residents' rotations in a women veteran's comprehensive primary care clinic. Following observation, individualized feedback was given in-person and emailed to residents regarding domains of trauma-sensitive communication.

2. Target audience

The target audience was medical residents ranging from PGY1-PGY3, completing a two-week rotation in a women veteran's comprehensive primary care clinic at a VA hospital.

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3. Objectives

The measurable objectives for this educational resource were to improve providers' confidence in and self-perceived skill in two main domains. These domains were:

1) Trauma-related communication (comfort discussing trauma and mental health in general, knowledge of responding sensitively to trauma disclosure, and understanding of trauma-informed care)
2) Patient-centered interviewing skills broadly (e.g., general communication skills, using motivational interviewing techniques)

4. Activity description

We tested the effect of focused communication training that included direct observation and feedback from a clinical psychology fellow on medical resident communication skills and trauma-sensitive care. Participants were medical residents (n = 8) completing a two-week rotation within a comprehensive women's primary care clinic at a VA hospital. This program was determined to be a non-research activity through the VA Connecticut Institutional Review Board Research Office and categorized as a quality improvement project.

5. Training

Patient appointments used for training were selected randomly from the patient panel of the day. A clinical psychologist familiar with the women's clinic and female veteran population served as the trainer and met with each resident for 3–5 min to introduce the purpose and goals of the intervention. The resident was encouraged to choose from a list and/or identify his/her own goals for the interview that the trainer focused on for the observation (Appendix A). With patient permission, the trainer sat in the exam room to observe the resident's interview.

During the observation, the trainer rated resident communication regarding trauma-related issues (e.g., mental health, trauma history, domestic violence), using a checklist that reflected concrete elements of trauma-sensitive care developed from, 1) the Substance Abuse and Mental Health Services Administration's (SAMHSA) principles of trauma-informed care[1] and, 2) feedback from all VA VISN1 Military Sexual Trauma Coordinators. Additional feedback focused on patient-centered interviewing skills through the resident's use of motivational interviewing techniques (e.g., using open-ended questions, affirmations, reflections, and summaries).

The resident and trainer met for 5 min after the appointment to discuss the observation of the clinic visit and provide timely verbal feedback; the trainer provided detailed written feedback via email later that day. The feedback process was iterative, such that the resident could identify new goals for the next patient visit based on previous feedback. Residents were also provided resources for reviewing patient-centered interviewing principles and SAMHSA's principles of trauma-informed care. The observation and feedback protocol was conducted three times on three separate days during the resident's rotation.

6. Assessment

Between April 2016 and May 2016, 8 residents completed the training during their rotation in the women's primary care clinic (male = 5, female = 3). They ranged in training level (PGY1 = 3, PG2 = 4, PGY3 = 1) and intended specialization (e.g., internal medicine, cardiology, geriatrics/palliative care). The majority (n = 5) of residents had not completed a rotation in the women's clinic previously.

Residents were given a brief survey at the start of their women's clinic rotation assessing their self-perceived comfort with and use of patient-centered approaches, and understanding of trauma-sensitive care. Items were rated on a 7-point Likert scale indicating level of agreement with each statement. Survey items were pulled from existing resident evaluation tools,[2,3] along with items developed specifically for this study to evaluate elements of trauma-related communication (Appendix B). Upon rotation completion, they were re-administered the survey and given the opportunity to provide written qualitative feedback about the intervention.

Stata software version 13.1 (StataCorp, College Station, TX) was used for statistical analyses. Wilcoxon signed-rank tests compared medical resident scores on items before and after the training program (Table 1). Results indicated statistically significant improvement in provider confidence in communication skills, comfort discussing trauma, knowledge of responding sensitively to trauma disclosure, and understanding of trauma-informed care. There were no significant changes in residents' perceptions of their patient-centered interviewing skills, comfort discussing mental health, or use of motivational interviewing techniques.

Qualitative feedback was consistently positive, indicating the residents found the training useful and unique compared to their other experiences during residency. Sample feedback included:

> *"… very helpful feedback, especially in regards to letting patients know and ask permission prior to touching them and being more sensitive to those with MST and childhood trauma."*

> *"I feel as if this was one of the more helpful learning experiences I have had so far in residency. I wish we received more feedback in our medical training."*

> *"We don't often get observed feedback for patient interviews and I really enjoyed critical analysis of my interactions."*

7. Evaluation and impact

The educational resource in this project was the use of a clinical psychologist integrated into the primary care clinic providing "in-vivo" observation of patient interviews and timely feedback for residents. Two items on the post-intervention questionnaire asked residents to evaluate the helpfulness and utility of the observation and feedback for their future practice. Results indicated residents rated strong agreement with both of these items (Table 1).

This pilot investigation of communication training in trauma-sensitive care was effective in improving resident comfort and perceived skills in communicating around trauma using both quantitative and qualitative methods. This educational intervention is a creative response to the Institute of Medicine's 2004 call for emphasis on patient-centered practices that address patients' behavioral health and social context.[4] In response, training needs within medical education identified by the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) include, 1) education about the role played by behavior and social factors in health, and 2) how to utilize this understanding to improve health outcomes – e.g., improving interpersonal and interprofessional communication skills among physicians so that they can effect better information exchange and collaboration with patients, their families, and health