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The Critical Care Communication project: Improving fellows' communication skills☆,☆☆

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ABSTRACT

Purpose: The aim of this study was to develop an evidence-based communication skills training workshop to improve the communication skills of critical care fellows.
Materials and methods: Pulmonary and critical care fellows (N = 38) participated in a 3-day communication skills workshop between 2008 and 2010 involving brief didactic talks, faculty demonstration of skills, and faculty-supervised small group skills practice sessions with simulated families. Skills included the following: giving bad news, achieving consensus on goals of therapy, and discussing the limitations of life-sustaining treatment. Participants rated their skill levels in a pre-post survey in 11 core communication tasks using a 5-point Likert scale.
Results: Of 38 fellows, 36 (95%) completed all 3 days of the workshop. We compared pre and post scores using the Wilcoxon signed rank test. Overall, self-rated skills increased for all 11 tasks. In analyses by participant, 95% reported improvement in at least 1 skill; with improvement in a median of 10 of 11 skills. Ninety-two percent rated the course as either very good/excellent, and 80% recommended that it be mandatory for future fellows.
Conclusions: This 3-day communication skills training program increased critical care fellows' self-reported family meeting communication skills.

1. Introduction

Each year, approximately 6 million people in the United States receive treatment in the intensive care unit (ICU). Twenty percent of these patients die either in the ICU or after intensive care, and many others survive with significant functional and cognitive impairments [1,2]. Many ICU patients lack capacity for medical decision making; therefore, intensivists typically discuss medical decision making with a patient's family or other decision-making proxies during formal or informal family meetings [3].

Multiple studies document that intensivist communication with families in the ICU is suboptimal [4–6]. Half of ICU family members do not understand the basic information about their loved ones' diagnosis, prognosis, or treatment [7]. Audio-recording studies of intensivists show that they often fail to address a patient's functional outcomes, attend to the family's emotional reactions, or inquire about a patient's religious and spiritual concerns [8–10]. Bereaved family members report that communication with physicians is critical, but recall this communication as unsatisfactory [11,12].

Professional organizations representing critical care physicians have responded to these data about suboptimal communication by calling for communication skills training for trainees. For example, the American Council of Graduate Medical Education's Residency Review Committee requires that all critical care programs offer training in medical ethics and palliative care, including communicating with families about end-of-life topics [13]. The American Thoracic Society has recommended

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that intensivists engage in educational experiences that provide skills training in core palliative care competencies with an emphasis on patient- and surrogate-centered decision making [14].

Still, few critical care fellowship programs provide evidence-based educational opportunities for fellows to improve their communication skills. A survey of pulmonary and critical care fellows documents minimal teaching of communication in the context of life-threatening illness and few opportunities for skills practice with supervision and explicit feedback from experienced faculty [15]. Most educational interventions for intensive care professionals have relied on didactic lectures or role modeling for passive learners, although neither of these strategies have been shown to improve communication skills [16]. Evidence-based communication skills interventions are urgently needed. In this article, we describe the development, implementation, and evaluation of an innovative, evidence-based program, Critical Care Communication ("C3"), for ICU fellows. This is the first communication skills program designed to improve intensivists' ability to communicate with family members over the course of a patient's illness. We hypothesized that self-reported communication skills would improve after the workshop and that learners would be satisfied with the workshop.

2. Material and methods

2.1. Program description

C3 is a 3-day communication skills training retreat for physicians training in critical care medicine. We modeled C3 on the National Cancer Institute–supported Oncotalk program [17–19], which resulted in sustained communication skills improvement among participating oncology fellows. We summarize C3 learning objectives in Table 1. We held the workshop outside the hospital setting and relieved participants of concurrent clinical responsibilities to enable them to focus on the training program.

2.2. Pedagogic approach

C3 involved 4 types of formal learning activities: (1) brief didactic overviews (limited to 20 minutes each), in which faculty present to all participants an evidence-based, step-by-step approach for core communication tasks in the ICU; (2) skills demonstration; (3) small group sessions for 5 to 7 fellows with a faculty facilitator, in which participants practice skills for several hours at a time with close supervision and immediate feedback, using actors simulating ICU family members in case studies prepared for this purpose; and (4) learner-directed role-playing exercises within small groups.

More than 80% of the 3-day schedule was devoted to small-group sessions. In these sessions, the 1:5 ratio of facilitators to learners and small group size ensured that all participants had multiple opportunities per day to participate in skills practice. In 45-minute sessions, the facilitator reviewed the clinical situation, invited a fellow to volunteer for role-playing, discussed the fellow's learning goals, observed the fellow's interaction with the standardized family, and facilitated feedback by the fellow's peers. Because most participants were anxious about talking to family actors in front of others and because their previous experiences with role-playing were often negative, faculty facilitators were careful to set ground rules to establish a safe environment in which experimentation was encouraged, support was provided, and success was recognized. The main teaching strategy was to emphasize positive feedback to encourage their skills and focus on the 1 area the learner identified as most important for practice. In addition, fellows were allowed to pause the role-playing exercise—or call a "time out"—if they wished to rethink an approach or ask for assistance from peers or faculty. The facilitator could also call a time out during the exercise to assist the fellow or to emphasize a teaching point.

Table 1
Critical care communication skills curriculum

Skill
• **Providing biomedical information clearly**
• **Obtaining the patient's values**
• **Talking about uncertainty**
• **Giving bad news**
• **Conducting a family meeting**
• **Helping families reach decisions**
• **Negotiating conflict**
• **Recognizing and dealing with one's own feelings**

Table 2
Description of clinical vignettes

Case	Initial clinical vignette
A	23-yr-old male admitted to the ICU with meningococcal meningitis with fever, hypotension, tachycardia, and delirium
B	60-yr-old male admitted to the ICU with pneumococcal sepsis with underlying metastatic colon cancer
C	84-yr-old male with a history of diabetes type II, chronic renal insufficiency, stroke, and Alzheimer's type dementia admitted to the ICU from a nursing home with pneumonia

2.2.1. Simulated family members in multiepisode, sequential cases

Throughout the retreat, the small groups used 3 cases chosen to represent the diverse situations occurring commonly in the intensive care unit (Table 2). Before the retreat, we trained 7 actors to play family members for these cases. The family actors received a written character profile and training in providing feedback to the fellows from the family perspective.

In each case scenario, the fellows met with the family 3 times as the patient's condition evolved. In the first encounter, fellows delivered bad news. In the second encounter, they negotiated goals of therapy. In the third encounter, they practiced discussing limitations of life-sustaining treatment or telling a family that their loved one had died. This sequential approach mirrored a typical clinical situation in the ICU and allowed the fellows to develop a relationship with the family.

A final session invited the learners to informally role-play situations they found challenging in their own practice. The fellows could volunteer to play family members or physicians; as family members, they could experience what it was like to be on the "other side of the stethoscope." This session was conducted late in the workshop, after fellows had worked with family actors in small groups, when fellows were more familiar with the methods, confident in the value of simulation, and willing to participate actively in challenging roles.

2.2.2. Preparing learners for skill transfer from simulated role play to clinical practice

At the end of the workshop, a didactic session ("Taking Skills Home") guided participants in how they might apply their new skills in clinical practice in their intensive care units. Fellows identified 2 communication skills that they would like to apply within the next month and documented them on a follow-up postcard. We mailed the card back to the fellows 1-month after the retreat, reminding them of their plan to practice these 2 skills.

2.2.3. Written curriculum

We provided participants with a written curriculum, including the case scenarios and 7 brief learning modules written by our faculty and annotated with relevant references. Both the scenarios and modules focused on situations that are commonly faced by intensive care physicians in daily practice.

To prepare the modules, we conducted a computerized, bibliographic review of literature published on these topics during the last 10 years. A librarian helped to ensure the completeness of this search, and 2 of the authors (RMA, JN) reviewed every article and selected those that would be of greatest value as references for the fellows, which we updated annually. An international group of experts in communication skills training,