



Contents lists available at ScienceDirect

## The American Journal of Surgery

journal homepage: [www.americanjournalofsurgery.com](http://www.americanjournalofsurgery.com)

# Improving surgical residents' communication in disclosing complications: A qualitative analysis of simulated physician and patient surrogate conversations

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## ARTICLE INFO

### Article history:

Received 9 May 2017

Received in revised form

31 August 2017

Accepted 19 October 2017

### Keywords:

Communication

Disclosure

Qualitative

Language

## ABSTRACT

**Background:** In this study, we explore surgical resident communication with simulated patient surrogates (SPs), in an Objective Structured Clinical Examination (OSCE).

**Methods:** We use discourse analysis (DA), a qualitative approach to analyzing language, to evaluate our residents' interactions with simulated patient surrogates. After identifying problematic communication patterns, we apply communication theory to discuss our findings and provide suggestions for improvement.

**Results:** Residents consistently use bluntness, defined as delivering the news abruptly and without adequate preface, and evasiveness, defined as avoiding giving the news, to deliver difficult information. In addition, some residents use neutral language when empathetic language is warranted; and some try to direct the response of SPs, who then become defensive. Residents use evasiveness most frequently, followed by bluntness. These delivery methods often result in poor communication.

**Conclusions:** We recommend further research in barriers to effective resident communication with patients, as well as future research on the positive effects of good communication on patient perception. Learning these skills will help residents to convey support and empathy to patients, thereby enhancing care.

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## 1. Introduction

Good communication skills are essential for physicians and have been shown to improve the value of care and increase patient safety.<sup>1–3</sup> Moreover, physicians with good communication skills have higher job satisfaction and less work stress.<sup>4</sup> Developing good communication skills is particularly salient for surgical residents, who tend to perform worse in nonverbal decoding skills (i.e., in assessing the nonverbal cues of patients) than residents entering primary care.<sup>5</sup> In addition, research suggests that good communication skills are integrally important to surgeons because they often deal with critically ill patients, and thus encounter difficult communication scenarios frequently.<sup>6</sup>

Disclosing a medical error is a difficult communication task that constitutes an important area of study. Patients expect both high-

quality information and empathetic support when receiving bad news from their physicians.<sup>7</sup> However, many physicians need to improve their communication skills in this area.<sup>8</sup> Thus, it is incumbent on residency training programs to teach the “interpersonal and communication skills” core competency of the Accreditation Council for Graduate Medical Education (ACGME).

In this study, we analyze simulated encounters between a physician and patient surrogates to examine the language residents use in disclosing complications during an Objective Structured Clinical Exam (OSCE). We use discourse analysis (DA), a form of language analysis that is often employed by communication scholars. DA is a qualitative method that analyzes language in naturally occurring interactions or texts to identify themes or meaning. “Discourse analysis looks at the ways in which speakers design the content of each turn at talk, at how interactions are sequenced and managed and also at speakers' choices in terms of vocabulary, grammar, intonation and rhetoric.”<sup>9</sup>

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## 2. Materials and methods

### 2.1. Case study

In the simulation, each resident was given the case of a 70-year-old male patient (Ken) admitted for preventive quadruple-bypass surgery who subsequently suffered a heart attack. Before the resident arrived at the hospital, another resident had ordered an electrocardiogram (EKG) because the patient was experiencing atrial fibrillation, but left without informing the oncoming resident that an EKG had been ordered. As a result of this failure in communication, the patient had an undiagnosed heart attack and heart failure for 2 days, during which time additional interventions could have helped minimize damage to his heart. Because of this error, the patient will now have a reduced quality of life. The resident is instructed to disclose to the SPs that their loved one suffered a heart attack that was missed by the surgical team.

### 2.2. Resident/SP training and instructions

Details of the OSCE were described previously.<sup>10</sup> Surgical residents were given the case history detailed above and standardized patients (SPs) attended a 3-h training session prior to the simulation and acted as patient surrogates (simulated family members). During the exercise, they were instructed to become more angry or upset when the resident did not disclose or take responsibility for the error. Albeit staged, this method still captures the spontaneous nature of physician-patient communication: both the resident and the surrogate patients were unsure how the other would respond.<sup>9</sup> The OSCE we used was similar, in content and structure, to a previous version that resulted in reliable measures of interpersonal and communication skills.<sup>10</sup>

### 2.3. Data collection

In order to analyze residents' communication, we first viewed 16 video-recorded performances (from 2012) of one 1st year and six 3rd year residents, as well as 9 critical care surgical fellows, who all received the aforementioned case during the Family Conference Objective Structured Clinical Examination (OSCE) administered by our Department of Surgery. This was the only time this particular scenario was used, so none of the residents had experience with this case, although the 3rd year residents had been exposed to a different OSCE scenario in a previous year. We decided not to isolate the residents and fellows by year because previous reports demonstrate that despite the differences in training levels among the residents, the difference in residency year seems to have no significant bearing on communication performance.<sup>10</sup>

### 2.4. Data analysis

The transcription coding symbols we used<sup>11</sup> were simplified to ensure readability and to reflect broader communication strategies, rather than emphasizing individual word units (Appendix I). In addition to our DA, the SPs and residents, as well as a clinical surgeon or nurse, rated residents in a checklist format on global skills such as their clarity in giving information, honesty, trustworthiness, and empathy and communication skills, among other measures.

An expert in DA (C.B.) viewed and transcribed the OSCE videos. Transcripts were read and the videos were re-watched using DA to look for patterns of problematic communication; specifically to identify patterns in how the residents delivered the news as well as word choices that led to defensive moments in the interactions. This methodology allowed the communication patterns to emerge

organically without preset assumptions about what communication problems we would find.

Relevant communication theory was then used to subdivide key characteristics of the interactions into 2 dyads that contribute to supportive or defensive communication environments based on the work of foundational interpersonal communication scholar, Jack Gibb (Appendix II).

In order to correlate our findings with the scores the residents received on the exam from the SPs, faculty raters, and critical care nurses, we aggregated and averaged the residents' scores and then compared our data to those scores.

## 3. Results

We found that residents disclosed the complication and/or error using 3 methods: bluntness, evasiveness, and forecasting, which have been defined and detailed elsewhere.<sup>12</sup> We focus on bluntness and evasiveness because these are the two delivery styles which should be improved.<sup>12</sup>

Bluntness has been defined as delivering distressing information very early on in the interaction and without a preface to provide context of the seriousness of the news.<sup>12</sup> Of the 16 residents we evaluated, 7 (43.7%) exhibited bluntness, at some time during the interaction. Some residents communicated bluntness and at other times used evasiveness, so the 2 are not mutually exclusive but can overlap during the same interaction.

Evasiveness, or "stalling," has been defined as taking longer than 2 min to deliver the news, using technical concepts, delivering the news in a monologue, and the use of euphemisms rather than direct language, to discuss the outcome.<sup>12</sup> To this definition, we also added focusing on other elements of the case to avoid talking about the complication and/or error, and asking leading questions to stall the disclosure of the complication and/or error. Of the 16 residents, 12 (an overwhelming 75%) used evasiveness at some point.

### 3.1. Bluntness

The simulation featured 2 pieces of bad news that the resident needed to deliver: 1) the patient had a heart attack, and 2) the surgical team failed to evaluate the EKG results that identified the heart attack. The following transcript excerpt shows how one of our residents abruptly shifted the conversation from a neutral topic (the reason the patient had surgery) to an emotionally charged topic (the heart attack). Dan and Dorothy are the names of the SPs.

**Resident:** And he had the operation, and the operation went well. Um, on day two after his operation, he did have a heart attack.

**Dan/Dorothy:** What?! P> (*The family reacts with shock.*)

**Resident:** He did.

**Dorothy:** Wait a minute, we don't know about this; you need to ... What?/

**Dan:** That was several days ago?

**Resident:** That was several days ago; we just learned about it today.

The resident closes the sequence by abruptly disclosing the error: the surgical team just learned about the heart attack, even though it happened several days ago. In this interaction, bluntness is used at two points during the disclosure.

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