SHARE

SIGN OF THE TIMES

Beyond Procedures and Checklists: Using Simulation to Remediate Communication and Professionalism Skill Challenges

Kirsten Broadfoot, PhD; Jeannette Guerrasio, MD; and Eva Aagaard, MD

Dr. Broadfoot is associate professor of family medicine, Dr. Guerrasio is associate professor of medicine, and Dr. Aagaard is professor of medicine and associate dean for educational strategy at the University of Colorado School of Medicine.

Effective communication has been linked with increased patient and physician satisfaction, improved patient adherence to treatment plans, more appropriate medical decisions, better health care outcomes, and fewer malpractice claims.[1] Unfortunately, the reverse is also true. Unprofessional behavior in medical school and/or communication skills performance in the bottom quartile of the USMLE Step 2 CS examination have a strong positive correlation with subsequent disciplinary actions by state medical boards.[1,2]

Communication and professionalism challenges typically revolve around contested interpretations of communicative practices. Humor, recognizing and discerning social cues, eliciting another's perspective, empathy, asking open-ended questions, emotion management, modeling, and relational dimensions of work (e.g. teamwork and collaboration, power and authority, and hierarchical expectations) are all points of difference.[3] Default patterns of communication within these dimensions of professional relationships are triggered by the clinical context in which an individual works and by life stressors. Addressing professionalism and communication lapses requires a holistic understanding of the problem at hand as well as strategies to objectively and specifically discern behavioral patterns.

The University of Colorado School of Medicine has developed a new program that attempts to remediate communication and professionalism lapses through attention to both the context and skills aspects of the problem. Many communication patterns of disruptive or distressed medical learners and physicians are learned behaviors.[4] As a result, remediation involves the unlearning and relearning of more effective communicative strategies. This unlearning and relearning process is grounded in an awareness of deficits and a willingness to reflect, process, and experiment. Both feedback from peers and experts and self-reflection are essential at all points of the remediation process and beyond. Without these components of practice, reflection, and specific behavioral feedback, remediation can falter if not fail.

After receiving a referral, the remediation team conducts an informal multisource assessment. Multisource evaluations include verbal and written reports from observing faculty and staff and details regarding specific events or complaints. These serve to define the context and content of the referral. The individual then meets with a remediation team that gathers a narrative reflection from the learner on challenges faced and events related to the referral, the time course of events, impact on work performance currently and in prior professional settings, and influence on personal life. The team also elicits a pertinent history of prior challenges and attempts at behavior change to address similar concerns as well as any other deficits or mental health issues that may be impacting performance. The individual is asked to describe several interactions and individuals that he/she has found challenging, and these situations are used in case construction for the remediation event. The goal of this assessment is to understand the personal and interpersonal challenges that the learner is facing as well as the context in which the behaviors occur. Through this assessment, patterns of behavior and contextual triggers are identified.

Within four weeks of the initial referral, the individual is invited to participate in remedial training at the Center for Advancing Professional Excellence (CAPE), which houses a state of the art simulation center, including standardized patients, who act as patients, colleagues, or others, and high-fidelity mannequins. The CAPE also provides a specialized case library and standardized patient team trained in remediation events for the campus and can record clinical interactions for review and assessment. Different simulation modalities are used to customize experiences for individual remediation needs, which often revolve around teamwork and collaboration and difficult or conflicted conversations. Providing feedback to the self—often involving a standardized patient engaging in behaviors similar to his/her own disruptive patterns—is a form of "teach back" that uses behaviorally focused feedback. This approach is considered essential to evaluating the effectiveness of the remediation event and the learner's ability to learn and retain skills necessary to prevent or manage conflicted situations in the future.

A typical remediation process involves a deliberative cycle of three case-based interactions with goal setting, video review, and reflection

continued on page 2

continued from page 1

followed by specific behaviorally focused feedback from the remediation team, standardized patients, and colleagues. The ability to record and review the learner's performance in real time is critical to increasing his/her awareness of undesirable behavior and its impact on others. A customized checklist grounded in the Calgary Cambridge Framework is used for remediation to assess the learner and guide feedback. Cases progressively increase in complexity, with the final case reflecting the critical event that led to the referral and providing the participant with an opportunity to "do-over" the interaction and situation. After the final case, the remediation team and the learner debrief on performance, observations, recommendations for further skill development, and next steps with their referring program or unit. A written report with general and case-specific observations of the learner's performance is sent with corrective and reinforcing recommendations to the referring program or unit for follow-up and support in the clinical environment. Most individuals require only one session for intervention, and progress is gauged through repeated contacts with the referring program or unit, review of subsequent evaluations, and presence or absence of recurrent reported events.

This remediation process—grounded in customized experiences, objective observation of skills, specific behaviorally focused feedback, a deliberative experiential cycle of multiple opportunities for learning and performance, and video review and reflection—has enabled the University of Colorado School of Medicine to support both learners and practicing physicians at many points in their professional development. The use of diverse simulation modalities enables highly customizable and authentic reconstruction of experiences, enhancing the efficacy of the remediation effort. In the last year, and as a result of this practice, the remediation team has seen increased requests for team remediation efforts as well as earlier awareness and intervention for learners and high-performing faculty. Although early feedback is positive, further study is needed to assess the effectiveness of this program on both short-term and sustained behavioral change.

References

1. Makoul G, Curry R. The value of assessing and addressing communication skills. JAMA 2007; 298(9):1057.
2. Papadakis M, Teherani A, Banach M, et al. Disciplinary action by medical boards and prior behavior in medical school. N Engl J Med 2005; 353(25):2673-82.
3. Ginsburg S, Regehr G, Hatala R, et al. Context, conflict, and resolution. Acad Med 2000; 75(Suppl):S6-S11.
4. Swiggart W, Dewey C, Hickson G, Spickard W. A plan for identification, treatment, and remediation of disruptive behaviors in physicians. Front Health Serv Mgmt 2009; 25(4):3-11.

SGIM