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"Could I add something?"Teaching communication by intervening in real time during a clinical encounter

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Abstract

Supervising learners communicate places faculty preceptors in a classic educational dilemma. What should a preceptor do when the learner is not communicating well and is not asking for help? What usually happens, in our experience, is that the preceptor decides at some point that they can't stand it anymore—then they interrupt the learner and takes over the conversation. Interrupting in this way, however, comes at the cost of deskilling the learner. Thus the authors have developed an alternative teaching strategy designed for communication tasks such as giving serious or bad news. In the strategy recommended here, the preceptor `sets up' the possibility that the preceptor may intervene in the encounter. If the preceptor does intervene, the preceptor explicitly hands the conversation back to the learner; and afterwards, debriefs the learner. This method is designed to decrease the risk to the patient while maximizing learning. It offers a way to teach communication skills more effectively in clinic using intentional goal setting with learners, careful observations, intervention when the conversation is not going well, and reflective feedback based on the learner's goals.

Supervising learners communicate places faculty preceptors in a classic educational dilemma that has not been addressed in the medical literature.

> Dr. Z is faculty preceptor for an internal medicine resident, Dr R, and is participating in a visit with a patient, Mr. C, who has metastatic colon cancer. The resident is thoughtful and careful, and is reasonably knowledgeable. As the resident is asking about chemotherapy side effects, Dr Z notices that the patient's face becomes red and he looks away, emotional cues that the resident seems to overlook. Dr. Z faces a familiar dilemma: does she jump in and take over the conversation, to help the patient at the cost of displacing the resident? Or does she

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just let the fellow continue, and risk leaving the patient's issues undiscovered and unaddressed?

During this encounter, Dr Z faces a choice between allowing a learner to get the practice and experience she must have versus ensuring that a patient receives the care needed.[1, 2] For minor procedures, such as a lumbar puncture, ethical principles exist to guide Dr Z.[2] If supervising a lumbar puncture, Dr Z would make sure that the resident: (a) has seen a lumbar puncture before; (b) knows the steps necessary to perform the procedure; and (c) has a means to request assistance from the preceptor for assistance without alarming the patient. Teaching a communication task, like giving serious news, is similar to the lumbar puncture in some ways. The preceptor should ensure that the learner: (a) has seen another physician give serious news competently; (b) knows an approach to giving bad news (one well-known approach is summarized in the acronym SPIKES);[3] and (c) has a way to ask for assistance during the conversation.

However, supervising communication is different from a lumbar puncture, and here the medical literature offers little guidance. What should a preceptor do when the learner is not communicating well and is not asking for help? What usually happens, in our experience, is that the preceptor decides at some point that they can't stand it anymore—then they interrupt the learner and takes over the conversation. Interrupting in this way, however, comes at the cost of deskilling the learner. Thus the authors have developed an alternative teaching strategy during years of teaching internal medicine residents, oncology fellows,[4] and palliative medicine fellows, and over the past two years have formalized this strategy. The strategy is designed for formative supervision of communication tasks such as giving serious or bad news. Because these tasks are usually performed by residents or fellows, our experience with it is based on these more advanced learners. However, it could well be useful for preceptors working with medical students in more basic tasks like history taking. In the strategy recommended here, the preceptor `sets up' the possibility that the preceptor may intervene in the encounter. If the preceptor does intervene, the preceptor explicitly hands the conversation back to the learner; and afterwards, debriefs the learner. This method is designed to decrease the risk to the patient, and prevent deskilling the learner, while maximizing learning.[5]

The Perils of Interrupting

The common pitfall occurs when preceptors watch a learner communicate less skillfully than they believe they could do themselves. In the case above, the learner is doing an `ok' job with the communication but has missed at least two emotional cues. What should the preceptor do? Many preceptors would interrupt the conversation and take over (in order to make an explicit empathic comment, for example)—leaving the learner off to the side.

The collective experience of the authors suggests that `interrupting and taking over', while common, ought to be retired as a teaching practice. The patient may feel that the preceptor is the `real doctor', and may lose trust in the learner who, after the preceptor leaves, resumes the role of primary care provider. The learner may feel embarrassed, discouraged, disheartened, or even shamed, in being displaced, especially if the preceptor then completes the encounter without reinvolving the learner. These negative emotions can interfere with learning: a learner who reacts defensively (“I was going to do that”) may not see what the attending was doing; a learner who feels embarrassed may decide that she can not work with this attending again (“She takes over and never lets me learn how to care for patients”). Finally, the preceptor may be missing an opportunity for learning. During the debriefing, the preceptor can explain exactly why he decided to act—that there were emotion cues to which the learner did not respond.

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Why Watch While the Learner Leads?

Shouldn't the faculty preceptor do most of the talking, thus role modeling good communication? The answer is no: role modeling alone is not enough to build expertise. There is no question that role modeling done well is an important method of teaching communication,[6] and when preceptors decide to intervene, one of the ways they use the intervention is to role model a better way to communicate. However, a number of educational studies that examine the acquisition of profession expertise conclude that there is no substitute for practice followed by feedback that engages the learner in reflection and plans for future action and learning.[7–11] Consider again the procedural skill required for a lumbar puncture. Would anyone contend that a resident could learn how to do a lumbar puncture without hands-on practice? Never! Yet, with communication, the absence of teaching methodology, faculty development, and time all conspire to reduce much communication teaching to passively watching experts.

One objection to allowing learners to lead part of the conversation can be handled straightforwardly. An inexperienced learner need not lead an entire conversation, particularly if it is complicated and involves strong emotions. For a learner who has seen another competent physician give serious news, and who knows an approach, it may be enough for them to assess what the patient knows and give the bad news. The preceptor and learner could plan for the preceptor to take over at that point and attend to the patient's emotion and develop a treatment strategy. After this conversation, if time allows, the preceptor could debrief the learner both on the learner's own performance, and perhaps one aspect of the preceptor's performance. Once the learner has mastered these skills she can attempt to deal with the patient's emotions or suggest a treatment plan. Over time, as her skills improve, the learner can conduct more of the conversation under the preceptor's watchful eye.

Teaching communication by observing learners is more complicated—and more painful—than teaching by role modeling. As a preceptor, it is painful to watch learners fumble, get stuck, occasionally blunder (as anyone does when learning a new skill). It's also complicated to decide when intervening would be in the best interest of the patient and the learner. For a lumbar puncture knowing when to step in is easier as the desired outcome is clearer. If the learner has made a couple of well-aimed attempts but no spinal fluid is dripping out of the needle, both the learner and preceptor would conclude that it is time for the preceptor to step in. On the other hand, when communicating serious news, learners often have only a vague idea of what a `good job' would look like; they often lack a clear standard of excellent practice and lack the observational skills to pick up the emotional and informational cues that are visible to an expert. (A good job in giving serious news has occurred when the doctor manages to articulate the news; the good job is accomplished in detecting and responding the patient's emotional reactions, adapting the information to the patient's ability to understand, and guiding the patient towards a clear view of the next steps.)[12]

A vague notion of what constitutes a `good job' in communication leads many learners, when given the opportunity to talk, to plow forward (as in the case above) when they are uncertain, rather than turn to the preceptor for assistance. Therefore, a preceptor committed to teaching based on allowing the learner do some of the talking must be prepared to intervene. In this way, competency-based training can occur in the clinic.

A Roadmap for Intervening Strategically in a Real-Time Clinical Encounter

For the past 2 years, the authors have been teaching the following roadmap in a faculty development program for oncologists.[11] This roadmap requires a small time investment prior to having the learner see the patient, but this upfront investment provides considerable

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advantages when it comes time to give feedback. And the roadmap can be adapted for use on-the-fly—not every step needs to be used every time one teaches.

1. Prepare learner before going in the room

Typically, learners will present some aspect of the patient to the faculty preceptor before they return together to the clinic or hospital room. Before going in to see the patient, the preceptor needs to negotiate how the learning will occur--about how much of the conversation the learner will do, the feedback that would be helpful, and the conditions under which the preceptor might intervene. Determining how much of the conversation a learner can do requires that the preceptor understand the learner's perception of what's difficult (“What do you find difficult about giving this kind of serious news?”). This enables the preceptor to suggest a specific aspect of communication for the learner to practice, and a specific strategy for the learner to use (“How about if you try to ask what the patient has already heard about the CT, does she know why it was ordered?”). The preceptor can then describe the possibility that he might intervene at some point: “I'm going to watch carefully as you talk so I can give you some feedback later. If you get stuck, look over at me or ask me if I have anything to add; I might also join in if I am concerned that the patient needs something.”

2. Introduce yourself and your role to patient

If the preceptor asks the learner to introduce the preceptor upon entering the room, the receptor can then set the patient's (and learner's) expectations about how the preceptor will participate. After being introduced by the resident, the preceptor might say, “Hello, Mrs Z, nice to meet you We work collaboratively, so as Dr. [resident] explains things I may add a point occasionally, or she may ask me to commment.” This enables the resident to maintain her role as the lead physician in the encounter.

3. Observe the learner's communication skills

Since the most effective feedback results from giving examples from the encounter, it is helpful to take notes so that later, when giving feedback, the preceptor can report specific observations or sentences used by patient or learner to illustrate what the preceptor observed. Folding a piece of paper in half gives us a column for “what the learner did or said” and “what the patient did or said” that facilitates the preceptor's ability to track both the patient's and the learner's behavior. (The preceptor may also want to mention to the patient that notes are being taken to help the preceptor follow the conversation and remember what was covered.)

4. Decide if an intervention is needed

A preceptor may intervene in a conversation to either support the patient, or to support the learner. An example of an intervention to support the patient would be if a patient requires attention to emotions that are causing significant distress that the learner is not addressing effectively, and the preceptor judges that allowing the conversation to continue would cause significant harm. An example of an intervention to support the learner is if the preceptor observes the learner becoming overwhelmed by their own emotions during the encounter.

5. Frame your intervention as adding value

The preceptor can frame an intervention as adding value, rather than displacing or negating what the learner has said by saying: “Could I add something here?” Using a question invokes the politeness of asking, and enables the learner and the patient to view the preceptor's role as essentially supportive of the learner. After the preceptor has made the point as concisely as possible, control of the encounter can be given back to the learner. For

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example, we might say, “Dr [resident], could I ask you to finish this up by talking about the next steps?” This enables the learner to resume the role of primary clinician in the encounter, and enables the patient to see the learner as the responsible clinician. In addition, it enables the preceptor to continue observing the learner's communication skills.

6. Include the reason for intervening in the debriefing with the learner

After the intervention, the preceptor should start by asking the learner for a self-assessment involving the original learning goal. “How did you feel you did assessing the patient's knowledge before giving the serious news?” Next, the preceptor should reinforce what is accurate in the learner's self-assessment. Rather than simply giving a feedback `sandwich' (positive point, negative, then another positive), our experience is that learners are more engaged when they are working on goals they have chosen.[13] The most effective feedback focuses on one or two important points that directly relate to learner goals, rather than superficially covering many different issues.

During this feedback, the preceptor should acknowledge the intervention directly. “I did find myself adding something.” Our practice is to ask the learner explicitly if they understood what made the preceptor intervene and to be transparent about our rationale. Citing specific observational data about leading to the intervention enables transparency, for example: “When Mrs Z sighed a second time, I felt there was something going on that we needed to understand, so that emotional cue was what led me to join the conversation. Did you notice her sighing?” Preceptors can leverage the value of role modeling by asking, essentially, “what did you see me do?” and “what effect did my intervention have on the patient?”

7. Prime the learner for future challenges

Spending a moment debriefing the learner about the intervention can enable you to point out areas of future learning about communication. Our practice is to emphasize the importance of looking ahead to future encounters rather than looking backwards to what the learner `should have said' which they cannot change. For example, a preceptor might say “So the next time you are giving serious news, you might remember to watch for non-verbal emotional cues like sighing—they are incredibly useful.”

Troubleshooting Interventions in Real-Time Encounters

Becoming intentional about how one intervenes as a preceptor can result, as with any new skill, in finding some problems. One kind of problem occurs if the learner withdraws after the preceptor intervenes, and doesn't seem to want to re-enter the conversation. This most often means that the learner was not prepared for the intervention, and suggests that the preceptor inquire gently about the learner's reaction—and use it to improve the way the preceptor prepares the learner the next time. Another problem is when the preceptor feels like things `aren't going well' but cannot quite diagnose what the learner is doing poorly. In this situation, our experience suggests that the preceptor intervene only if the patient is at risk; if the preceptor cannot give the learner some clear direction in the debriefing, the preceptor is unlikely to add learning value.

Conclusion

What happened in the case mentioned in the introduction?

During the visit, Dr Z leaned forward (she was sitting next to the resident, and slightly behind), and said “Could I add something here? I just have noticed, Mr C, that you have been sighing and I have been wondering what that means.” Mr C smiled and said, “Yes, doctor, you're right. I can't stop thinking about how I will tell my daughter. She will want to

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help me but she is already so busy with her own family. I cannot place my own burdens on her." Dr. Z said, "Well, thank you for explaining that—it sounds like something we must address very carefully." Dr Z looked over at the resident. "I wonder, Dr R, if you could talk about some ways we could help Mr C talk to his daughter?"

Later, when Dr Z and the resident left the room, the resident said, "I was so glad you asked about the sighing. I don't think I would have done that but it was really interesting. In fact, it was the turning point in the conversation." Dr Z said "It is terrific that you noticed exactly what I was doing. What is the take-home lesson for you". The resident said "I have got to be better at watching for the non-verbals." "That," said Dr Z, "is a great piece of learning for today."

Because face-to-face teaching time is scant, preceptors need to maximize its value. The strategy described here offers a way to teach communication skills more effectively in clinic using intentional goal setting with learners, careful observations, intervention when the conversation is not going well, and reflective feedback based on the learner's goals. In our experience, this strategy is more likely to result in teaching success—where the learner walks away from the encounter with a sense of having acquired or refined a useful skill.

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