SUMMARY OF MEETING RE CF I AND II
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I. CF Faculty Development

Time for faculty development is a significant issue

Required

Repeated half-day (T,Th) session August

Intro: 1) Clear statement of the problem – importance of dr/pt communication skills; the problem is how we teach communication (implicit teaching; hidden curriculum teaching poor dr/pt relationship 2) Evidence basis (outcomes) for good communication skills 3) CF faculty are not the problem, because they have been selected for outstanding dr/pt relationship skills 4) The goal is to provide them with additional tools for explicitly addressing dr/pt communication skills *in their small group teaching*

Exercises: (just possibilities) 1) Dyadic listening exercise 2) Dyadic or SP empathy exercise 3) Dyadic or SP telling vs. persuading 4) Feedback – addressing a difficult problem behavior with a student 5) Working with physician and patient emotions 6) Point of view writing

Meta-exercises: (follow-up to exercises) 1) Cultivating self-awareness 2) Cultivating other awareness 3) Practicing reflection

Follow-up: 2-3 small group (T,Th) sessions throughout the year using brief written narratives to reflect on teaching challenges related to cultivating patient-doctor relationship.

Optional

Faculty interested in more in-depth attention to how they teach about dr/pt relationship
Maxi model:

1. Preliminary meeting to identify problems and/or goals
2. JS reviews session tape/faculty journals examples of relationship/communication teaching
3. F/u meeting to discuss progress toward goal
4. JS reviews additional session tape/faculty continues journaling, noting examples of successes and problems
5. Final meeting to discuss what has been achieved

Mini model: Steps 1-3 only

This option will be contingent on available time

II. Patient-Doctor Medical Education CF I and II

The following approach is in keeping with our belief (and the recommendations from LCME and other professional bodies) that lecture time should be held to a minimum. Thus, the thrust of this approach is to emphasize case-based teaching on dr/pt communication through a range of

patient cases designed to trigger challenging communication issues (difficult ER patient, patient w/hx of sexual violence; bereaved patient; psych patient).

CF I

1. Sonya will modify her Professionalism lecture to incorporate more Reynolds pt/dr and geriatric objectives
2. Johanna will adapt her Humanities lecture to incorporate Reynolds dr/pt relationship objectives

CF II

1. Johanna will adapt her 3 hours of teaching time to incorporate Reynolds' pt/dr relationship grant objectives

CF I and II

1. Sonya (w/input as needed from Johanna) will rewrite cases to emphasize pt/dr relationship teaching points; and develop teaching guides to accompany each case

Clinical Teaching:
Patient-Doctor Relationship

I. Meeting with Geriatrics faculty

- a. Describe a typical clinical teaching encounter with a medical student
- b. How much time would you estimate you spend with your learner?
- c. How often do issues about the patient-doctor relationship come up in a typical clinical encounter?
- d. How often do you explicitly address the dr/pt relationship in clinical teaching?
  1. How do you introduce the topic?
  2. How do you attempt to "teach" about this topic?
- e. Do you think this issue needs additional attention beyond role-modeling?

II. PDR "mini-thoughts" for clinical teaching

- a. The main concept is reflection on process as well as content
  1. Content – the medicine; the symptoms, the lab values, the differential diagnosis, the medications
  2. Process – how the medicine is addressed; interaction between pt/dr
- b. Three levels of PDR reflection
  1. Basic relationship-building
  2. Difficult relationships
  3. Special problems

III. Basic relationship-building

- a. Basic concepts
  1. Awareness of other
     - a. Attentive presence (attentional focus, deep listening)
     - b. Empathy – understanding the patient's perspective, priorities, values
     - c. Awareness and comfort with pt. feelings
     - d. Respect for pt
  2. Awareness of self
     - a. Where is your attention?
     - b. What frustrates/scares/angers you in the encounter?
     - c. How do you anticipate pitfalls?
     - d. How do you maintain your equilibrium?
     - e. What do you appreciate about the encounter? What do you enjoy about your pts? What makes it a positive encounter for you?
  3. Connection with the pt.
     - a. How do you establish an emotional connection with the pt?
     - b. How do you balance connection with equanimity?
  4. Basic communication skills – 4 E's –
     - a. engagement (welcome)
     - b. empathy (cognitive and emotional; paraphrase, clarify, understand pov)

c. education (vertical vs. mutual)
d. enlistment (buy-in, negotiation, incorporation of pt views)

IV. Difficult relationships

a. Dysfunctional patterns

1. What are some dysfunctional patterns you have found yourself in w/pts?
2. How have you attempted to change them?

b. What is the story you're telling about the patient? Are there other, more useful stories available to you?

c. What are your own negative knee-jerk reactions to certain patients or situations? How do you manage them?

d. Angry, demanding, hopeless pts

e. Other (identified by clinical teachers)

V. Special problems

a. Patients who are excessively talkative, rambling
b. Patients who are not fully mentally competent
c. Working with family members/caregivers
d. Other (identified by clinical teachers)

VI. Model for "mini-thoughts"

a. Decide which level is most relevant for a given clinical encounter
b. Choose ONE area of most importance for this encounter
c. Facilitate a 3 min discussion using a Socratic (question-based), reflective, and self-disclosing method

Clinical Teaching – Patient-Doctor Relationship

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a. How do you establish an emotional connection with the pt?
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Clinical Foundations FACULTY DEVELOPMENT WORKSHOP July, 2010

Goal: To explore ways of applying relationship-centered care (RCC) in the CF teaching context (small groups)
Review principles of RCC
Parallel process: dr/pt, teacher/student
This means that concepts of relationship-centered care can be modeled in the relationships that are formed between teacher and students

Exercises:
Listening: 3 minutes of dyadic sharing/listening; discuss stressful decision; ONLY listen, be present; switch; discuss experience as sharer/listener

Empathy only: 3 minutes of sharing/empathy only; discuss difficult situation; ONLY respond with empathy, verbal, nonverbal; discuss experience of sharer/listener

I'm gonna change your lifestyle: dyadic exercise; choose your worst habit; other persuades you to change it; discuss experience as changee/changer

Working with emotions: anger, fear, sadness (SP roleplay?)

Cultivating self-awareness
How did I feel? Am I experiencing any difficult emotions that need to be addressed? Was I present with the patient? Did I listen well? Was I respectful? Did I demonstrate empathy? Did I understand my patient's perspective?

Engaging in reflection:
How did that interaction go? Any problems – in me, in pt – that need addressing? How can I improve? What can I follow-up on?
Parallel chart: think of a patient; construct a parallel chart (feelings, thoughts, info not "relevant" to medical chart – respecting HIPAA)

POV writing
pov patient writing (already used); maybe try pov student writing

Standardized patient roleplay:
geriatric driver interviewed by medical student

Surfacing relationship issues in the small group setting:

> **SP interview and discussion of preceptorships**
> **How to connect with the patient**
> **Barriers to connection**
> **How is the student feeling?**
> **How is the patient feeling?**

Grounding relational platitudes

- **How do you convey that you respect the patient's views, values?**
- **How do you build trust?**
- **How do you convey caring?**
- **How present is the student? Where is the student's focus?**

Overcoming relational challenges

To humanize an I-It relationship

- **Express gratitude – thank you**
- **Express appreciation – I admire**
- **Express empathy – hard**
- **Express caring – how can I make you more comfortable?**
- **Importance of authenticity, not algorithmic**

BRAINSTORMING IDEAS FOR FACULTY DEVELOPMENT CF AND BEYOND

Small group process

How do you create safety?
How do you deal with common problems?

- **silent member**
- **dominating member**
- **lack of constructive criticism**
- **lack of reinforcement**
- **"bad" behaviors (chronically late, missed assignments)**

Patient-centered medicine

- **Pogo-e presentation 9modified)**
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Penetrating Assumptions about Elderly Patients (geriatric)

- **Combination of reading poetry, first person narratives, role-play, reflective writing to consider assumptions and stereotypes**
  - **Medically complicated, but ultimately not interesting**
  - **Long-winded**
  - **Out of touch**
  -
- **Emphasis on development of close reading and interpretive skills**

Writing the Difficult Patient (geriatric)

- **Reflective writing about a difficult patient encounter**
- **Point of view writing about a difficult patient encounter**

Parallel Chart (geriatric)

- **Start keeping a "parallel" chart about patients you see**
  - **Things you notice about the pt/family member that are too trivial, tangential, irrelevant to be entered into the "real" medical chart**
  - **Feelings of pt/family member that do not belong in the chart**
  - **Your own feelings about the pt/family member**
  - **Your ideas, imaginings about pt/family (how does the pt feel about her diagnosis? What questions do you think she has that have not been answered?)**
  - **Questions you have about the pt, her situation, her diagnosis that have not been answered**

Moving Closer to the Patient's Experience (geriatric)

- **Close reading and interpretation: poetry, first person narratives by patients, family members, physicians**
- **Readers' theater**
- **Special topics: Alzheimer's/dementia; end-of-life decision-making; stereotypes/assumptions about geriatric pts**

<u>Breaking Bad News</u> (geriatric)

- **What the patient feels**
- **What the family members feel**
- **What the doctor feels**
- **Guiding principles**

<u>Working with Emotions in Medicine</u>

- **Positive emotions/attitudes**
  - **caring, patience, compassion**
  - **how positive emotions can go wrong**
- **Negative emotions**
  - **helplessness, resentment, anger, guilt**
  - **loss and grief**
- **Finding emotional balance**
- **Emotional connection vs. emotional detachment**

<u>Communication Skills</u>

- **Listening skills**
  - **active listening**
  - **listening for the patient's story**
- **Empathy/understanding other perspectives**
- **Engaging disagreement (noncompliance)**
- **Brief debriefing:**
  - **What did patient like about encounter?**
  - **Any needs not met? Questions not answered?**
  - **Suggestions for improvement**

<u>Narrative Typologies</u>

- **Listening for different types of stories**
- **Chaos – dry for help**
- **Restitution – find it and fix it**
- **Journey – illness as testing and personal transformation**
- **Witnessing – bearing witness to suffering**

<u>Other possibilities</u> (not faculty development)

- **In-vivo small group student-pt interviewing followed by reflection session**
- **In-patient sessions**
- **Involvement with CF IV - Through the Eyes of the Patient**