Enhanced Psychosocial Skills Training for Palliative Care Fellow-Physicians

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BACKGROUND

Palliative care physicians need sound psychosocial skills to navigate the complexities of end-of-life work. This poster describes a novel psycho-educational program associated with the Palliative Care McGill Post-Graduate Medical Education Fellowship. This ongoing psychosocial skills training group has been in place for 6 years and aims to develop the communication skills of fellows by helping them to:

- ❑ Identify psycho-social dilemmas in end-of-life care for patients and families
- ❑ Increase self-awareness and understand the value of a peer-group settings in facilitating learning
- ❑ Identify core communication challenges in order to practice effectively
- ❑ Understand death, dying, and bereavement from multidisciplinary perspectives
- ❑ Examine personal coping patterns, behaviors, and strategies

METHODS AND METHOLDOLOGY

Development

- ❑ This program was constructed in parallel with the learning objectives of two Canadian accreditation bodies in Palliative Care with a special focus on communication skills, as well as psychosocial case conceptualization, treatment planning, and clinical interventions.
- ❑ The program employs both the action-reflection and discrimination model of clinical supervision (Bernard & Goodyear, 2013). The trainers, a staff physician and a psychologist, took on three supervisory roles: the "**teacher"**, the "**consultant**", and the "**counsellor**". The three pedagogical focus areas for skill building included: "**conceptualization issues**", "**intervention issues**" and "**personalization issues**". An emphasis on the fellows' feelings/emotional states was made with the goal of enhancing non-defensive subjective awareness and emotional impact in a clinical encounter.

Structure: Verbatim Report

- ❑ Training included 90-minute bi-monthly meetings using verbatim case report as the primary method. Fellows (*n* = 4 - 6) were instructed to compose a brief (3 to 5 page) report before each session following a semi-structured format.
- ❑ The verbatim report instructions were adapted from the McGill University Health Center Clinical Education for Spiritual Care Program (Lambert, 2013). Fellows were advised to choose a case from which they believed they could learn something of value. Reports were not exact transcripts and were based on memory, consisting of two parts:

Part 1	Part 2
Preliminary Information: Who was present during the conversation?	**Analysis:** Major themes of the visit. Fellow interpretation
Psychosocial History	**Tendencies:** (tendencies in fellow responses, e.g.: advice-giving, clarifying, interpreting, minimizing, probing, reassuring, etc.)
Training Goals: What is your hope for outcome following your presentation?	**The Relationship**
Initial Observations	**Diagnostic assessment / Psychological profile**
Record of Visit *Example:* Pt: Hello Dr. Smith Dr: How are you today Mr X? Pt: (not making eye contact) You're the doctor….you should know the answer to that without asking me! Dr: Tell me about it. Pt: (very quietly). I could not sleep.	**Socio-cultural observations**
	Self-evaluation
	Chart entry
	Future directions

Peer-Group Presentation

- ❑ Fellows presented the verbatim in the peer-group facilitated by the two trainers. The other fellows would then select parts to play (e.g., the patient, the physician) followed by a reading of the record of visit. Trainers would then encourage a group conversation to deconstruct the case. Themes include fellow responses to the verbatim as well as clinical hypotheses as to the underlying processes at work. Fellows were encouraged to come with a question to guide the conversation. Attempts were made to challenge superficial engagement and defaulting to medical language.
- ❑ Trainers would occasionally provide small psycho-education presentations on recurring themes of clinical importance (e.g., personality disorders, collusion and triangulation dynamics, mood disorders and demoralization, death anxiety, etc.)

Program Evaluation

- ❑ Fellows completed detailed and anonymous mid-term and final evaluations which included feedback to supervisors and suggestions for improvement. Resources permitting qualitative exit interviews (conducted by a third party, recorded, and then transcribed) were employed to allow for more detailed impressions.

RESULTS OF TRAINING

The following excerpts were selected to illustrate preliminary, general reflections and themes based on exit interviews.

Value of the Peer-Groups

- "…I thought it was very nice to hear that some of the other residents were having the same frustrations…"
- ".. .I am not the only one who is having these tricky conversations and having a hard time figuring out how to maneuver through them."
- **"…**So, I would sometimes be ashamed if I felt angry by a patient or frustrated. But when other residents voiced the same feelings, I felt much better about it".

Professional Lessons Learned

- "…The training was very good at helping me gain insight into the various dynamics that happen."
- "…So I think one big lesson was how am I feeling in this situation? And what emotions and feelings and assumptions am I bringing into this that may be affecting the way I communicate with the family?"
- "…Learning how to be open […] "it's nice to try to see the good in people and give them the benefit of the doubt […]"
- "I often need to be able to set boundaries…"
- " There are going to be patients and families who are going to have issues with situations that I can't fix or going to have symptoms I can't control. […] that is just the reality of it and not to take that on as a failure in myself. But accept that that is part of the work…"

Personal Lessons Learned

"…I've learned to be much more aware of the type of language that's used when I have interactions with patients that I might have missed out on before having the course …"

"…it is better to identify that you are feeling irritated or that you're feeling angry and then try to set that aside and move forward in the communication than to ignore the fact that you're feeling irritated in the encounter and let it color the way you interact with the family."

"I think it helps to slow down as I'm having a conversation and checking in on the patient from time to time and just try to understand what agenda they have."

Value of verbatim training

"…Oh, yeah I know what is going; this is exactly like the situation that we discussed in the course. This patient is feeling angry probably because of X, Y and Z." So I think yeah I definitely learned something from discussing, looking at discussing my own scenarios and also the other residents'…"

"I just think that it is important to note that we don't get this type of instruction in any other form, in medical school, in residency, in family medicine.[…] they don't get this type of sensitivity training to how to conduct discussions, how to interpret the discussions you've had.[…] This is the only form of instruction that I have come across and I think that it's extremely valuable."

DISCUSSION

- ❑ **Clinical implications:** Results suggest that fellows gain practical information concerning their psychosocial skills training, techniques and strategies that they may wish to apply to their practice settings. Fellows reported finding the training valuable and challenging. One fellow reported it as a "keystone" of the fellowship program.
- ❑ **Limitations:** Occasional difficulties in keeping a regular schedule, lack of an evidence base upon which to build the program, reliance on anecdotal support and fellows memory for verbatim reporting, and a tertiary care environment. The fellows reported a preference for the addition of more directive or instructive components, more frequent meetings, and more consistency in scheduling. Some fellows reported the potential hindrance of the physician as both an evaluator in the larger curriculum as well as a trainer, stating the dual role may have impacted the ability to share openly and honestly when presenting cases.
- ❑ **Ethical Disclosure:** An initial report of this program appears in the conference proceedings of the *International Journal of Whole Person Care* (5)1.

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