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Quality and Patient Safety Project Summary

Development and Implementation of Direct Observation Tools for Serious Illness Conversations in Internal Medicine Residency: A Mixed-Methods Study

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INTRODUCTION

Accreditation Council for Graduate Medical Education (ACGME) guidelines now require clinical experiences in palliative care for all internal medicine (IM) residents, with competence in goals of care (GOC) discussions as a core competency.[1] However, communication training in medical education is often viewed as lacking, with no clear consensus on how to best teach these skills.[2] Despite various strategies currently used to teach communication skills, such as workshops, lectures, standardized patient encounters, and short video instructions, there is often a lack of real time specific feedback on actual clinical experiences. Many review articles point toward direct observation as particularly beneficial for this reason.[3] The aim of this study was to assess internal medicine (IM) residents' current experience with GOC communication training, followed by the development and implementation of direct observation tools for feedback during clinical encounters. The impact and experience of using these tools was then evaluated using both qualitative and quantitative analysis.

METHODS

This was a mixed-methods study conducted from September 2020 through March 2023 at the University of California, Los Angeles (UCLA) Division of General Internal Medicine. The study was approved for exemption by the institutional review board (IRB# 19-001792). Novel direct observation and feedback tools were developed using needs assessment survey data and expert opinion. These direct observation tools were used with IM residents at all stages of their training both on inpatient palliative care consult services as well as inpatient general medicine services under the guidance of an attending physician during patient encounters. There was intentional variability in how the checklists were utilized in order to allow for flexibility depending on the patient scenario, attending specialty, and time constraints. A post-intervention survey was conducted three years after the tools implementation assessing resident self-reported comfort with these conversations. Focus groups were also performed with residents who had used the checklists and volunteered for participation without compensation. Using thematic analysis and a combination of deductive and inductive methods, the three authors independently identified codes, which were grouped into themes. Multiple iterations of codes and themes were developed until consensus was reached among all three authors, with final themes and representative quotes.

RESULTS

The needs assessment or pre-intervention survey was completed by 58 of 181 IM residents, while the post-intervention survey was completed by 28 of 193 IM residents. Comparison data using chi-square analysis showed increased comfort with code status and GOC conversations (p=0.01 and p=0.019, respectively). There was no statistically significant change in resident comfort with code status discussions upon a patient's clinical change (Table 1). Focus groups explored how material was learned prior, benefits of the checklists, challenges, and areas of improvement (Table 2). Focus group data highlighted the versatile way the checklists were used, without impacting the learning experience.

DISCUSSION

This pilot study demonstrates the development and implementation of novel direct observation tools for teaching communication skills to IM residents. Qualitative post-intervention data revealed that residents' level of comfort improved for both code status and GOC discussions. Quantitative data supported both of these significant changes.

The focus group analysis revealed the diversity in how the checklists were implemented, including before or after an encounter, in person or via telephone, and with a hospitalist or palliative care trained faculty member. The variability did not seem to impact the quality of the experience, suggesting that the tool is versatile and that the impact is not lost despite variations in utilization or supervising physicians. We believe the tools, with guided explanation for both instructors and trainees, can be easily implemented into any IM residency program.

The focus groups also identified ways to improve the checklists with regards to content and implementation. It was felt that some conversations did not fit within the framework of the checklist, and it was not clear from the

Table 1. Pre-intervention and Post-intervention Survey Analysis: Self-Reported Comfort

	Pre-intervention (N=57)				Post-intervention (N=28)				
	Strongly Agree	Agree	Disagree	Strongly Disagree	Strongly Agree	Agree	Disagree	Strongly Disagree	p value
Comfort with GOC Discussions	12.28%, 7	49.12%, 28	36.84%, 21	1.75%, 1	35.71%, 10	50%, 14	10.71%, 3	0%, 0	0.01*
Comfort with Code Status, Admission	36.84%, 21	63.16%, 36	0%, 0	0%, 0	60.71%, 17	35.71%, 10	0%, 0	3.57%, 1	0.019*
Comfort with Code Status, Clinical Change	21.05%, 12	64.91%, 37	14.04%, 8	1.75%, 1	42.86%, 12	46.43%, 13	10.71%, 3	0%, 0	0.18

Chi-square (%,n); *=significant p= <0.05

Table 2. Focus Group Derived Themes and Representative Quotes

Categories	Themes	Quotes
How material was learned prior	Acronyms as an insufficient method	"I've learned so many acronyms that I don't remember any of them…"
	Modeling as a commonly used method	"We see it modeled by other people we interact with, and then we just sort of pick it up on our own"
Benefits of checklists	Providing a framework	"It provides a nice framework to approach these kinds of conversations… at least a starting point. It gives you a way to approach these conversations that can be very challenging; you don't even know where to start and I think this creates a very good framework."
	Providing sample language for difficult discussions	"A lot of us have a sense of the things we want to ask or the information we want to gather, but we may not have an idea of how to ask it in a way that's not blunt or potentially inflammatory."
	Improving confidence through availability	"Knowing there is a sort of checklist or tool available does improve confidence. I think only because it again gives you a way of approaching a problem."
	Improving the quality of feedback	"The checklist was helpful, because he recognized when he filled out the form that there were some things I would improve on, and he was reminded that maybe there are some things he will incorporate in the future too"
Challenges in application	Variability in content of discussions	"Maybe you didn't check all the boxes but it was it was still a good conversation to have…it's hard to use a checklist to fit in a not one size fits all situation"
	Late application	"I think maybe this experience would have been more important to me had it been in my intern year…When you are impressionable, and you're still learning your basic skills and haven't fallen into habits"
Areas to improve	Providing specific examples	"Responding to emotion in an empathic manner of body, language, and nonverbal behaviors– we all do that in different ways. And so sometimes it's helpful to have a learning tool associated with that, or have like specific behavior, because some of the other checklist items give specific examples"
	Incorporation of interns	"I think it would be very helpful having it as part of the intern intake curriculum, just to let them know that these tools exist." "I was never asked to be a part of goals of care discussions as an intern, and so maybe we need to be reminding interns or incorporating them"

tools' instructions that not every aspect of the checklist must be completed. This required only minor editing to the instructions in order to clarify for the future. Residents also felt that providing more examples of suggested responses, such as a script of how to respond to emotion, would add additional guidance. Furthermore, the trainees felt that if they had more emphasis on direct observation with communication skills earlier in their training, they may have experienced more benefit. In practice, emphasis on using the tools can be placed on early trainees while on their ACGME mandated palliative care educational experience.

There were several important limitations to this study that warrant discussion. The COVID-19 emergency began shortly after implementation of the checklists, and this delayed the study. In many cases, the typical model of trainees seeing patients with their supervisors was rationed to limit exposure, decreasing opportunity for direct observation. Due to the length of time needed to fully implement the checklists, this study was unable to capture the ex-

act pre-study population for post-study analysis. However, because the residents' training year and training program were similar, the survey was thought to still capture the overall impact of the curriculum over time. There were also low response rates to our pre-intervention and post-intervention surveys. Although the focus group data showed theme consensus amongst participants, there was a relatively small number of residents who attended the focus groups. Lastly, about one third of residents surveyed post-intervention had exposure to the checklists. It is possible that other cultural or systematic changes could have contributed to the significant outcomes in this study, though the authors are not aware of any other major implementations to the IM resident curriculum during this time that could account for these findings.

CONCLUSION

In summary, this pilot study has demonstrated improvement in IM residents' self-reported confidence with leading serious illness discussions, following implementation of direct observation and feedback checklist tools. We believe these tools can be easily incorporated into other IM residency programs, especially with new ACGME emphasis on communication education.

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