Advanced Communication Topics

*Facilitation Guide*

Series of 12 One-Hour Learning Sessions
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Introduction

Welcome to the DocCom Learning Curriculum. We believe that using this curriculum will enable your faculty to create an outstanding educational experience in some essential aspects of clinician-patient communication. When learners master the curriculum material, they will deliver higher quality patient care and more empathic care. For example, they will be more skilled in working with challenging clinical situations such as giving bad news or relating to an angry family member. This curriculum specifically assists learners striving to fulfill the ACGME competency requirements in clinician-patient communication.

Here are a few tips for using the learning curriculum.

- Assign the relevant DocCom module in advance.
- Require learners to answer the multiple choice assessment questions and one of the discussion questions by the evening before your session.
- Access their answers online and use them as triggers to the discussions in your sessions.

The DocCom editors, who have a wealth of experience in medical education and in residency education in particular, created facilitator notes based on established curricula at Drexel University College of Medicine and the University of Oklahoma, Tulsa. Any interested faculty member can easily deliver this curriculum in a series of one-hour sessions. We will be happy to consult with you on customizing it to your setting.

This curriculum is built around 12 DocCom modules. For maximum effectiveness, we suggest that you use the facilitators’ guides and the learners’ handouts, as well as the learners’ pre and post session assessment of conviction and confidence.

Learners’ answers to assessments provide documentation of completion of the modules. This documentation may prove helpful in accreditation situations, such as with Residency Review Committee (RRC) accreditation. (If you need help accessing the feedback or documentation functions of the DocCom education platform, contact us.)

We have created pre- and post-session “Conviction and Confidence” scales for each module. Pass out and collect the “pre” at the beginning of each session and the “post” at the end. These pages document the session and attendance at the session for Program and accreditation purposes.
**Introduction: Skills Exercises:**

For each session, be certain that you set aside time for skills practice. We recommend a number of skills exercises. Most exercises involve role plays, but individual faculty might want to substitute standardized patients or visits to the wards as time and resources permit. Below are some pointers to make skills exercises more effective.

Please emphasize to your learners that we expect them to make mistakes whenever they attempt to learn new skills. Time and practice, with feedback from self-evaluation, peers, standardized patients and faculty, will be essential for mastery. Please also emphasize that feedback should be offered with a helping spirit, trying to suspend on the one hand our natural “evaluative and judgmental streak” and on the other hand our natural defensiveness when receiving criticism. Feedback should be behaviorally specific and recipients of feedback should seek clarification of feedback they don’t understand.

The module checklists help observers to offer behaviorally specific feedback. You can refer to these checklists when setting up the goals for an exercise. You can also ask learners to fill out the checklist after an interview and to refer to it when they offer feedback.

**Introduction: Design sessions to ensure effective feedback:**

Each skill building exercise should be designed to ensure participants’ success:

- **Before the actual exercise, clearly state limited and achievable goals you hope participants will accomplish.**

  Examples:

  In this next role play we will practice skills for responding to strong emotions. Let’s review these skills. [Ask a learner to list several specific skills that he/she will use in the role play.]

  It often helps to practice verbalizing a behavior before beginning the actual exercise, i.e., “What kinds of questions would you ask to elicit the patient’s concerns?” or “What is an example of a legitimate comment?”

- **Agree with the learners what their tasks will be during the exercise. Example: “Let’s plan to spend five minutes discussing in pairs the interviewer’s use of opening skills.” “How did it feel to use those skills?”; “Were there any barriers to using the skills?”; “How would you do it differently next time?”**

- **In early exercises, try to put learners at ease: acknowledge that it is anxiety provoking to interview in front of a group, thank the learner for volunteering, etc.**

- **Agree on an appropriate time frame for the exercise. With standardized patients or role plays, short exercises (3-5 min) are more effective. They facilitate “micro-counseling” – giving specific feedback about an individual skill – and a short exercise allows learners to replay it to get it right.**

- **Be sure to tell the learners that if they are unsure, or run out of things to say, they can call time out.**

- **Keep time or assign a timekeeper.**
Use this sequence in giving feedback to provide the best support for the learner and facilitate additional learning:

a. The learner who interviewed critiques him/herself first. Be sure to ask the learner to state what he/she did well, followed by what he/she would do differently next time. If the learner seems hesitant or unsure about using one of the skills or asking a sensitive question, you might ask if he/she could articulate what was getting in the way.

b. Ask the other learners in the group to offer their feedback.

c. Offer your feedback, making sure you accentuate the positive, but do not overlook weaknesses.

If working with a standardized patient, be sure to ask the patient for comments on the learner’s effectiveness in using certain skills, and, if appropriate, for comments on his/her emotional reactions to the learner’s use of skills, i.e., “How did you feel when the learner said...?”

As you begin the session, let the learners know you will invite their feedback and suggestions. Soliciting learners’ opinions of how the session went and suggestions for doing it more effectively next time shows your openness and appreciation of feedback and sets a good tone.

For those interested in further reading on enhancing teaching skills of communication, we recommend DocCom Module 40 (Feedback), and selected chapters from “The Medical Interview” by Lipkin, Lazare and Putnam, which can be found in the DocCom Resources section. (Note: you must have set up at least one learning group in order to gain access to this section, which also includes other useful resources.)
Pre-session Assignment: Ask clinicians to complete the multiple choice questions and the question of their choice from Discussion Question 2.

Check-in: (5 min): Ask questions like: “What’s happening?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask clinicians to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
- Describe core concepts underlying the therapeutic efficacy of the clinician-patient relationship.
- List the therapeutic goals of medical encounters.
- Describe strategies that advance the therapeutic aims of your medical encounters.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (25-30 min) Open the discussion by asking about the main insights they had from reading Module 3. Review the most interesting points from their replies and from their answers to multiple choice questions and discussion questions. Emphasize the following points:
- The Biopsychosocial Model, first articulated by George Engel, views people as integrated biological and psychological beings who behave in certain ways in their social contexts. Changes in any one of these dimensions of human functioning affect all of them.
- The field of psychosomatic medicine has produced copious scientific evidence confirming the biopsychosocial model. As examples: stress, depression and social isolation are associated with physiologic and anatomical changes that promote disease. Unhealthy behaviors such as smoking and drug abuse also promote the pathophysiology of diseases.
- The biopsychosocial model assumes the essential unity of mind, body and spirit. Thus, in thinking scientifically about illness and disease, you must consider the biological, psychological, behavioral, and social factors that contribute to your patient’s illness.
- You can learn to use your understanding of biopsychosocial interactions to share and discuss information with your patients and counsel them so they can change their reactions to stress, recover from depression, reengage with their loved ones and community and change maladaptive behaviors.

Ask: “Can anyone give us an example of how this model applies to one of your patients?” The next concepts to go over are these: “Who knows the difference between disease and illness?”

Answer: Disease is objective – can be identified under a microscope or with abnormal lab tests or imaging. Illness is subjective – what the patient feels. You can have disease without illness (i.e., hypertension or a small breast cancer that haven’t been diagnosed yet) and illness without disease (i.e., hypochondria) and most patients who have some disease, have an illness presentation that depends on the patient’s personality, personal history, fears, concerns, affective state, social support, etc.

Parallel concepts are curing and healing.
Ask: “What is the difference between curing and healing?”

Answer: You can cure disease with drugs or surgery. You heal with your words. Question: “What do patients come to see you with?” They come with illnesses and part of the problem of medical care is that we immediately search for disease. If we are to effectively help patients, we must appropriately respond to their illnesses and diseases.

The next concept to discuss briefly is the distinction between the Science vs. the Art of Medicine.

Ask: “What is the Art of Medicine?”

Answer: The Art of Medicine is using yourself as an instrument of healing. You use your knowledge, experience, values, judgments, skills, well-being and caring in the words you choose with your patient. Next, discuss what is therapeutic about the clinician-patient relationship?

- Remembering that for thousands of years every society has had healers, and the medical profession has been around since before Hippocrates, and until the modern era, clinicians had little in the way of effective diagnostic and therapeutic modalities. In fact, much of what our predecessors had at their disposal was ineffective or harmful.
- Yet patients have always come to clinicians and often were healed.

Ask: “What do we have in common with our clinician ancestors and with modern day native healers that we can articulate and use in our care of patients?”

Write on the board the clinicians’ answers and have a brief discussion of each. (The answers to this question can be found in Module 3 and in the attached article.) (Novack, DH - Therapeutic Aspects of the Clinical Encounter.)

Skills Development: (20 min)

Show VIDEO: Module 18: [TOC: Ask About Sex/Expanded History/click on video icon duration – five minutes]. This depicts a healing encounter with an internist. Dr. Williams noticed a patient’s distress during the sexual history and decided to take an extra five minutes to address the issues. It was a turning point and healing moment for the patient.

- Debrief Video Exercise: Ask the clinicians: “What did Dr. Williams do that created a healing encounter?”
- Some answers – she noticed the patient’s distress – the sigh when the patient first started talking, she showed she was comfortable asking about a difficult subject, she was non-judgmental, she made empathic statements and legitimized the patient’s feelings, she gently pushed the patient, even after the patient said, “that’s it.” She used the patient’s metaphor and made the beginnings of a solution non-threatening, she asked, “Would you be willing to open the door a little?” She was silent and let the patient talk, express painful emotions, etc.

Conclusion/Next Steps: (5-10 min)
Ask clinicians to take a few minutes to fill out the post session questionnaire. Then go around the room and ask each of the clinicians to say something they learned from this discussion and which of the skills will they begin to apply in the next week in their clinical work?

Next Session Assignment:
Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
The Biopsychosocial Model and Therapeutics - DocCom Module 3

Learner Handout

Rationale: Clinician-patient encounters are therapeutic in and of themselves; independent of diagnostic and therapeutic activities of proven effectiveness. For thousands of years, before the modern era of efficacious drugs and other medical interventions, sick people have sought care from clinicians. Many of these clinician experienced relief and started on the road to healing. How did this happen? If we can identify the therapeutic elements of clinical encounters, we can be intentional about maximizing these elements with patients. There are several core concepts that help us understand the therapeutic efficacy of clinician-patient encounters: the biopsychosocial model, understanding the definitions and distinctions between disease and illness, curing and healing and the science and art of medicine.

Learning Goals: At the completion of this session you will be able to:
  o Describe core concepts underlying the therapeutic efficacy of the clinician-patient relationship.
  o List the therapeutic goals of medical encounters.
  o Describe strategies that advance the therapeutic aims of your medical encounters.

Key Principles:
  o Independent of your accurate and appropriate biomedical diagnostic and treatment activities, clinical relationships can be therapeutic or counter-therapeutic!
  o You can enhance therapeutic and healing aspects of encounters by identifying windows of opportunity and employing specific interview skills in those moments.
  o You can learn communication and counseling strategies that help your patients cope with stress and illness and change unhealthy behaviors.
Pre-session: Conviction and Confidence:

How **convinced** are you that it is important to practice within a biopsychosocial model of care?  
(0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **convinced** are you that there are therapeutic strategies that are timeless and core to the practice of medicine?  
(0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **confident** are you that you can practice within a biopsychosocial model of care AND that you can use psychosocial therapeutic strategies to facilitate healing in your patients?  
(0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10
Post-session: Conviction and Confidence:

How **convinced** are you that it is important to practice within a biopsychosocial model of care? (0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **convinced** are you that there are therapeutic strategies that are timeless and core to the practice of medicine (0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **confident** are you that you can practice within a biopsychosocial model of care AND that you can use psychosocial therapeutic strategies to facilitate healing in your patients? (0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Check-in: (5 min): Ask questions like: “What’s happening?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask clinician to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
  o Describe the challenges facing clinicians when sharing information with patients.
  o Describe and demonstrate a systematic, relationship-centered approach to sharing information.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
  o Inquire about clinicians’ prior experience: Discuss learners’ responses to Module 10 discussion questions.
  o Ask about their experiences with sharing information with patients: “What are some of the barriers?””
  o Module review: Ask what they found most useful in Module 10, either about the conceptual framework or the specific communication skills presented.
  o Instead of doing a module review, you might show example videos from Module 10. Choose one or more videos from the “ASK” section and one or more from the “TELL” section of Module 10 and ask the clinician what they think and if they see any barriers to using these skills.
  o Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: how sharing information with a patient made a big difference in his or her life or an insight you gained from sharing information with a patient that didn’t go as well as it could have.

Skills Development: (20-30 min) Show VIDEO: Module 10: (TOC: Strategy/Ask:Assess Needs/Ask Patient Understanding/click on video icon). While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.
  o Role Play: Ask clinicians to pair up (or do role play in front of the group). One learner will play a patient and the other the clinician giving information to the patient who is about 20 lbs overweight and has a new diagnosis of hypertension (150/100). Before the role play, the clinician will review the Behavior Checklist to use as a guide for the role play, being sure to cover at least the core components in each “ask-tell-ask” category. Ask clinicians to choose a particular skill from each category on the checklist to work on. The clinician will do relevant patient education for HT. Allow five minutes. Ask the clinician to do a self-critique and allow the patient to give constructive feedback. After about five minutes of discussion, clinicians can switch roles and repeat the process.

Debrief (5 min): Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc. Another approach to role play is to play the patient yourself, and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask colleagues for help. You
might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.
Conclusion/Next Steps: (10 min) Ask clinicians to complete the following pages on handout:
- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 16: Promoting Adherence and Health Behavior Change. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.

BEHAVIOR CHECKLIST:

ASK to assess patient needs:
1. Make sure the setting is conducive
2. Assess the patient’s physical and emotional state
3. Assess the patient’s informational needs
4. Assess the patient’s knowledge and understanding
5. Assess the patient’s attitudes and motivation
6. Assess the patient’s level of literacy

TELL information:
1. Keep any one presentation or statement brief
2. Use a systematic approach
3. Build on the patient’s prior experience/Praise successes
4. Personalize information
5. Use simple language/Avoid jargon
6. Choose words that do not unnecessarily alarm
7. Use visual aids and offer supplemental materials

ASK about the patient’s understanding, emotional reactions and concerns:
1. Assess and check the patient’s understanding
2. Elicit concerns and/or questions
3. Elicit and respond to the patient’s feelings
4. Assess barriers
Rationale: The essential goal of sharing information is to empower patients to optimize their health. Too often, physicians give patient education short shrift, simply telling patients what to do, and too often, patients leave their physicians’ offices with incomplete understanding of their illnesses and the next steps they must take. If we use specific communication skills and an organized approach, we can greatly improve our education of patients and help our patients achieve better physical and mental health.

Learning Goals: At the completion of this session you will be able to:

- Describe and demonstrate a systematic, relationship-centered approach to sharing information.
- Improve several communication skills that will enhance your sharing of information with patients.

Key Principles:

- Patients want to know preventive strategies, information about diagnosis, tests and treatment options, self-management strategies and likely short term and long term outcomes.
- The goal of sharing information is to enable patients to understand and cope with illness (and prevention) in collaboration with their clinicians.
- Skillful and compassionate sharing of information improves patient adherence and clinical outcomes.
- The fundamental relationship-centered strategy is to use repeating cycles of “Ask-Tell-Ask”.


**Pre-session: Conviction and Confidence:**

How convinced are you that using an “ask-tell-ask” strategy enhances patient understanding and adherence? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can share information with patients in a way that enhances their understanding and adherence? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10
Post-session: Conviction and Confidence:

How convinced are you that using an “ask-tell-ask” strategy enhances patient understanding and adherence? (0 = not at all; 10 = totally)

0    1    2    3    4    5    6    7    8    9    10

How confident are you that you can share information with patients in a way that enhances their understanding and adherence? (0 = not at all; 10 = totally)

0    1    2    3    4    5    6    7    8    9    10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Responding to Strong Emotions - DocCom Module 13

Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
  o Describe the effects (on patients and on clinicians) of clinicians’ empathic responses to strong emotions, as well as, the effects of ignoring strong emotions.
  o Identify likely origins of strong emotions.
  o Describe how clear personal boundaries promote clinical effectiveness and professional growth.
  o Demonstrate ability to respond empathically to strong emotions.
  o Describe situations that may require referral or medication as adjunctive responses to strong emotions.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
  o Inquire about learners’ prior experience.
  o Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
  o Personal experience.

Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can then discuss their answers in groups of 2-3 for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
  o In what circumstances are you aware when a patient is feeling strong emotions? In what situations are you caught off guard?
  o How do you respond to patients who get angry with you?
  o When patients demonstrate strong emotions, which of your reactions tend to help the situation resolve? Which tend to escalate discomfort in the room?
  o In your non-medical life, does fear, anger or sadness tend to cause you the most discomfort?
  o How do you determine whether you need specialty consultations with patients who are emotionally distressed? When do you consult your peers?
Skills Development: (25 min) Show VIDEO: Module 13: Responding to Emotions/Intense Anger/click on green icon. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- Debrief Video Exercise: “What skills were demonstrated that would be easy for learners to adopt?” “Which skills would be more difficult?”
- Role Play: Ask learners to pair up (or do role play in front of the group).
- Debrief (5 min): Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc. Another approach to role play is to play the patient yourself, and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask colleagues for help. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.

Conclusion/Next Steps: (5 min) Ask learners to complete the handout items, provide assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 41: Professionalism: Boundary Issues. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
Responding to Strong Emotions - DocCom Module 13

Learner Handout

Rationale: Illness often generates strong emotions in patients and their family members: fear, sadness, anger, shame, anxiety, resentment, bitterness and more. Sometimes you will be the target of these strong emotions. Seeking to understand the nature of these emotions, and responding directly using specific skills, tends to strengthen trust and relationship and promote healing. Many clinicians are reluctant to respond directly to emotions, especially strongly expressed anger, fear or sadness. Failing to respond, or responding reactively or defensively when your “buttons are pushed,” tends to weaken the relationship and diminishes both patients’ and clinicians’ satisfaction.

Learning Goals: At the completion of this session you will be able to:
- Describe the effects (on patients and on clinicians) of clinicians’ empathic responses to strong emotions, as well as, the effects of ignoring strong emotions.
- Identify likely origins of strong emotions.
- Describe how clear personal boundaries promote clinical effectiveness and professional growth.
- Demonstrate ability to respond empathically to strong emotions.
- Describe situations that may require referral or medication as adjunctive responses to strong emotions.

Key Principles:
- Strong emotions can originate in the patient or the clinician or the strong emotions can derive from the interaction between clinician and patient. Identifying the origin of emotions promotes clear boundaries and enhanced clinical effectiveness.
- Responding to emotions thoughtfully tends to strengthen the clinical alliance and promote healing; responding reactively or defensively tends to disrupt or weaken that alliance and diminish both patients’ and clinicians’ satisfaction.
- Strong emotions in clinician–patient interactions are neither good nor bad. They are a natural human consequence of life-changing events.
- Exploring clinicians’ emotions that arise in the interview as well as the ways that clinicians respond to patients’ emotions promotes personal and professional growth.
Pre-session: Conviction and Confidence:

How convinced are you that responding effectively to strong emotions is an essential clinician competency? 
(0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can respond compassionately, and without defensiveness to anger, sadness, fear or other strong emotions of patients and family members? 
(0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10
Post-session: Conviction and Confidence:

How convinced are you that responding effectively to strong emotions is an essential clinician competency? (0 = not at all; 10 = totally)

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How confident are you that you can respond compassionately, and without defensiveness, to anger, sadness, fear or other strong emotions of patients and family members? (0 = not at all; 10 = totally)

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What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Promoting Adherence and Health Behavior Change –
DocCom Module 16
Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
  o List and describe components of the five A’s model for helping patients change behavior; including behavior related to adherence to diagnostic and treatment recommendations.
  o List and describe the five “Stages of Change.”
  o Assess patients’ readiness to change and their conviction and confidence about change.
  o Demonstrate ability to explore and appreciate patients’ attitudes, values and feelings about behaviors and changes.
  o Respond constructively when patients voice resistance to changing a behavior.
  o Tailor your advice and assistance about adherence and other behavior changes according to patients’ readiness, conviction and confidence.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
  o Inquire about learners’ prior experience: Ask learners to mark pre-session conviction and confidence scales. Learners’ experience: Ask learners about experiences with patients surrounding adherence with recommendations and motivation for behavior change: “What were some of the difficulties?” or “What successes have they had?” (Bring in their answers to the online Module 16 discussion questions.)
  o Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
  o Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: what skills you employed (or failed to use) in an encounter with someone where you addressed adherence and behavior change and what you learned from your experience.

Personal Reflection: (A useful exercise, if you have time) A useful exercise, if you have time: Ask learners to jot down answers to these questions. If you have a large group, they can discuss their answers in groups of two to three for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion. Nearly everyone has attempted a change in personal behavior and those personal experiences can inform the clinician-patient encounter:
  o What behaviors of my own have I attempted to change?
  o What was easy about making the change?
  o What was difficult about making the change?
  o What helped me be successful?
  o If I relapsed, how did I feel about it?
Skills Development: (25 min) Show Module 24, Pre-contemplation Video. Cue up at “respect choice” and watch to 4:30, after “ask permission.” While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- **Debrief Video Exercise:** Ask the learners: “What skills were demonstrated that would be easy for learners to adopt?” or “Which skills would be more difficult?”
- **Role Play:** Ask learners to pair up (or do role play in front of the group). One learner will play a patient and the other the clinician. The learner playing the patient role may choose to play themselves attempting a personal behavior change or pick another scenario such as adhering to medication, weight loss or exercise.
- **Debrief (5 min):** Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc. Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learners can ask for time outs, if necessary, and ask colleagues for help. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.
- **Alternatively,** use one or more of the role play scenarios (attached).

Conclusion/Next Steps: (5 min) Ask learners to complete the handout items, provide assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 13: Responding to Strong Emotion. Complete the multiple choice questions and respond
BEHAVIOR CHECKLIST

Prepare:
- Guide dialog to behavior change issue (lifestyle factor, treatment adherence).
- Summarize relevant prior discussion (or available facts).
- Review or state association between behavior issue and health risks.
- (Tell) Specify intention and interest in discussing behavior change that would benefit patient.
- (Ask) Assess patient’s willingness to discuss this behavior.
- Negotiate agreement to discuss behavior.

Assess:
- (Ask) Seek to understand patient’s feelings, knowledge, beliefs and readiness regarding changing behavior.
- (Ask) Show curiosity and interest about patient and his/her context.
- (Tell) Reflect understanding of patient’s perspective.
- (Tell) State respect for patient’s autonomy/choice.
- (Readiness) (Ask) quantify (1-10 scale) patient’s conviction (interest) in changing behavior.
- (Readiness) (Ask) quantify (1-10 scale) patient’s confidence about changing behavior.

Advise:
- (Ask) Ask permission to provide advice or information.
- (Tell) Give specific advice (or endorse specific patient’s intention) to change.
- Give advice (or endorsement) in personalized, contextualized fashion.
- Respond with reflection and empathy when patient shows anger, frustration, irritation, defensiveness, ambivalence or embarrassment.
- Respond with praise or appreciation when patient shows enthusiasm, interest or determination.

Agree:
- (Ask) Elicit and clarify patient’s goals.
- (Tell) Share clinical goals.
- Demonstrate a collaborative stance by using partnership skills.
- Offer options that are appropriate to readiness, conviction and confidence.
- Negotiate and compromise until you can agree on simple and realistic goals for change.
**Assist:** Modify and calibrate use of skills and strategies for different situations (Stages of Change), as follows:

- **(Pre-contemplation)** For the patient who shows no interest in change:
  - Raise awareness through empathy.
  - (Ask) Use the conviction ruler to explore and elicit interest in change.
  - (Tell) Recommend informative handouts.
  - (Tell) Suggest role models, suggest support group or habit diary.

- **(Contemplation)** For the patient who shows ambivalence about change:
  - Underscore patient’s motivation through empathy.
  - When patient expresses resistance, reflect content back to him/her.
  - Affirm patient’s autonomy and choice.
  - (Ask) Use the conviction ruler to explore and elicit interest in change.
  - (Ask) Review patient’s understandings of the pros and cons of changing the behavior.
  - (Tell) Add or clarify information, as needed.

- **(Determination)** For the patient who is ready for action:
  - (Ask) Elicit patient’s options/ideas/strategies to enhance success.
  - (Tell) Suggest additional options.
  - Problem-solve to address and reduce barriers.

- **(Maintenance)** For the patient who is already making significant change:
  - Invigorate the action plan by celebrating success and affirming desired behaviors.
  - (Ask) Get details about lapses.
  - Problem-solve methods to resist temptation.

- **(Relapse)** For the patient who has resumed unhealthy behavior:
  - Re-invigorate the plans by showing empathy for the relapse/guilt.
  - Identify and celebrate successes prior to lapse or relapse.
  - Look for lessons in details of relapse situation.
  - Problem-solve methods to resist temptation.
  - Make statements affirming patient’s autonomy and choice.
  - Encourage trying again.

**Arrange:**

- Seek patient’s verbal agreement on details of action plan
- Arrange follow-up visit and arrange for referrals.
**ROLE PLAY SCENARIO – Hypertension**

**Patient:** You are 55 years old and healthy with hypertension (HTN) for many years. For years, clinicians have prescribed blood pressure (BP) meds but rarely have you taken them regularly. They always make you feel bad, plus they’re expensive. Besides, you need to feel in control; not controlled by medications. Instead, you work on your stress management and successfully maintain a daily regimen of aerobic exercise. But your BP remains high. You know that meds will lower your BP but you continue searching for non-medication treatments; recently exploring acupuncture and chiropractic; particularly since you feel great and that’s really why you usually resist suggestions to take medications.

You know that long-term high BP risks heart and kidney problems and you sure want to avoid that. If evidence of a problem ever developed, you would be really worried, perhaps causing you to rethink your priorities. That’s why you keep searching for something that works.

**Clinician:** You have been working with this 55 year old hypertensive patient for years. Although he has focused on nonpharmacologic treatment, including daily exercise, his BP remains well above target. He’s been prescribed medications, which he can afford, but he has never been compliant with them. A recent ECG reveals left ventricular hypertrophy, a new finding documenting end-organ (heart) damage from longstanding uncontrolled hypertension. Unless the BP becomes controlled soon, you fear the development of additional heart (MI/CHF), kidney (failure) or CNS (TIA/stroke) damage.

You plan to discuss medication compliance. Try using the five A’s:
- **Assess:** determine “Stage of Change”; apply confidence/conviction scale.
- **Advise:** help him focus on medications as the most reliable therapy to prevent future health damage.
- **Agree:** on goals.
- **Assist:** adapt your interventions to patient’s stage of change and level of conviction/confidence.
- **Arrange:** seek commitment to an action plan.

Remember to try “rolling with resistance” when it occurs.
ROLE PLAY SCENARIO – EXERCISE

Patient: You are 36 years old, healthy, 5’4” and weigh about 230 lbs, noticing weight gain of about 10 lbs each year for many years. Over the past year or two, you have noticed diminishing energy and easy fatigability. You are pretty sedentary and have a desk job. You come from a family of heavy people, and all seem healthy. You have never tried exercise and can’t imagine finding the time or having the energy. Physical exertion just doesn’t seem to fit your self-image. Anyway, overweight is normal, at least in your family, and it’s not on your list of possibilities for causing your current problems.

Your clinician has just completed a complete exam and extensive lab tests. You are expecting a medical explanation for your problems and hopefully an easy fix with a medication. You will be very surprised if the clinician recommends something other than a medicine, since you think that medicine is the only likely treatment to help.

Clinician: Your patient is 36 years old, healthy, 5’4” and weighs about 230 lbs. The patient has gained 10 lbs each year for many years. The patient is sedentary with a family history of obesity. The main problem is diminished exercise tolerance and easy fatigability.

Other than obesity, the patient’s comprehensive exam is normal and lab including thyroid, blood counts and function of heart and lungs are normal. You have concluded, with certainty, that the patient’s problems are due to de-conditioning (out of shape) and obesity, which you have just explained to the patient. The best therapy is beginning daily exercise, such as walking, biking, swimming, aerobic dancing—many options.

- **Assess:** determine “Stage of Change”; apply confidence/conviction scale.
- **Advise:** help patient focus on exercise as the most reliable therapy to improve exercise tolerance and raise energy as well as promote weight loss and overall health (i.e., prevent HTN, DM).
- **Agree:** on goals.
- **Assist:** adapt your interventions to patient’s “Stage of Change” and level of conviction/confidence.
- **Arrange:** seek commitment to an action plan.
- Remember to try “rolling with resistance” when it occurs.

**Next Session Assignment:** Read DocCom Module 13: Responding to Strong Emotions. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
**Promoting Adherence and Health Behavior Change**

**DocCom Module 16**

**Learner Handout**

**Rationale:** Patient education and counseling is a core function of all medical encounters and an essential component of quality medical care. Moreover, clinician use of effective communication and counseling skills promotes patients’ adherence to treatment and facilitates changes in patients’ risky health behaviors, including smoking, problematic substance use or unsafe sexual practices. Clinician’ health behavior counseling rates fall well below the targets recommended in Healthy People 2010, the US Health and Human Services’ blueprint for preventive and behavioral health objectives for the nation. Barriers to the adoption and implementation of effective interventions include time pressure, lack of training, limited patient and clinician resources and inadequate organizational elements to ‘support and sustain clinician’ efforts. Many clinicians are skeptical about spending valuable time on patient’ education and counseling, while others feel frustrated, inadequately prepared or lack confidence in counseling skills.

Despite these barriers, good evidence from multiple studies indicates that clinicians who participate in specific training interventions do a better job of patient-centered health behavior counseling. Moreover, interventions that combine clinician’ training with supportive prompts or other reinforcement through organizational interventions produce significant changes in patients’ health risk behaviors.

**Learning Goals:** At the completion of this session you will be able to:

- List and describe components of the five A’s model for helping patients change behavior, including behavior related to adherence to diagnostic and treatment recommendations.
- List and describe the five “Stages of Change.”
- Assess patients’ readiness to change and their conviction and confidence about change.
- Demonstrate ability to explore and appreciate patients’ attitudes, values and feelings about behaviors and changes.
- Respond constructively when patients voice resistance to changing a behavior.
- Tailor your advice and assistance about adherence and other behavior changes according to patients’ readiness, conviction and confidence.

**Key Principles:**

- You will encounter many patients who are not willing or are unable to adhere to treatment recommendations or change an important health behavior. You can help by using skills and systems of proven effectiveness, such as the five A’s (Assess, Advise, Agree, Assist, Arrange).
- Important skills not emphasized in “Essential Elements Modules” include the following:
  - Ability to assess “Stage of Change” and conviction and confidence about changing.
  - Expression of respect for patients’ autonomy in making choice.
  - Eliciting the pros and cons of behavior change from patients.
  - Listening respectfully to patients’ statements of resistance (or commitment) to change and reflecting them back to patients.
  - Collaborating and reaching agreement on goals that match patients’ “Stage of Change,” conviction and confidence.
  - Steadfastly avoiding attempting to persuade patients with low conviction and avoiding trying to direct or prescribe action plans if conviction or confidence is low.
- You will be most efficient and effective at helping patients change and adhere to treatment
recommendations if you adjust your use of skills named in the five A’s model to match patients’ readiness for change and their conviction and confidence about change.
Pre-session: Conviction and Confidence:

How **convinced** are you that promoting adherence and behavior change is an essential clinician competency? 
(0 = not at all; 10 = totally)

0    1    2    3    4    5    6    7    8    9    10

How **confident** are you that you can competently promote adherence and behavior change with patients? 
(0 = not at all; 10 = totally)

0    1    2    3    4    5    6    7    8    9    10
Post-session: Conviction and Confidence:

How **convinced** are you that promoting adherence and behavior change is an essential clinician competency? (0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **confident** are you that you can competently promote adherence and behavior change with patients? (0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Communicating with Depressed Patients—DocCom Module 27
Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
- Describe the differences between depressed affect and clinically significant depression.
- Inquire about the nine symptoms of major depression.
- Ask five questions to evaluate suicidality.
- Demonstrate empathic interactions with depressed patients.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
- Inquire about learners’ prior experience: Ask learners about experiences with communicating with depressed patients. “What has been difficult when attempting to establish a diagnosis of depression?” or “How have you responded when depressed patients begin to cry?”
- Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
- Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: perhaps a story of depression associated with suicidality or of depression presenting with predominance of somatic symptoms.

Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can then discuss their answers in groups of 2-3 for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
- Considering your personal life and those of your friends and family, to what extent are you able to differentiate depressed feelings and affect from clinically significant depression?
- Have you or anyone you have known been treated for depression? How have those experiences influenced your attitudes and skills related to working with depressed patients?
- Has anyone you have known personally ever been suicidal? How has that experience influenced your attitudes and clinical care?
- In what ways have you encountered stigma with respect to depression? In what ways could stigma affect the way you interact with and support your patients?
Skills Development: (25 min) Show VIDEO: Module 27: Diagnosis/Assess Suicidality/Video Example: begin about 2:00 minute and play to about 5:15 minute. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.
  o Debrief: (5 min) Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.

Conclusion/Next Steps: (5 min) Ask learners to complete the handout items, provide assignment for next session and collect handouts. The handout items are:
  o Conviction and confidence post-session scales
  o A skill they plan to practice in the coming week in their clinical work
  o What else they learned in the session today
  o What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 28: Domestic Violence. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

- Respond to depressed affect with empathy.
- Adopt attentive nonverbal position, such as: leaning forward, head forward.
- Respond with soft, warm and caring tone of voice.
- Ask about the nine symptoms of depression.
- Ask about suicidality and ask the five follow-up questions.
- Address stigma or resistance with relationship building strategies (such as PEARLS; Module 6) and sharing of information about depression.
- Tell the diagnosis clearly and directly and in a supportive manner.
- Share information about depression, using simple language without jargon, short sentences and checking for understanding.
- Explain treatment recommendations using simple language without jargon, short sentences and checking for understanding.
- Ask about patient’s perspectives on the nature of the illness and ideas for treatment and respond with respect and acceptance of those perspectives.
Rationale: The illness of depression and its variants are common in society, and more common in people who are seeking medical care, but the diagnosis is frequently overlooked. Social stigma and negative attitudes limit the insight, interest and ability of both patients and clinicians to discover depression. Patients with depression often complain of physical symptoms and clinicians frequently fail to connect these somatic problems with other clues to establish the correct diagnosis. Treatment of depression is effective and many patients go unnecessarily untreated, continuing to suffer, miss work and cause distress in friends and families. This module presents basic concepts, as well as special communication challenges and focuses on strategies and skills that will assist patients to become more comfortable discussing symptoms and more likely to accept the diagnosis and treatment of depression.

Learning Goals: At the completion of this session you will be able to:
- Describe the differences between depressed affect and clinically significant depression.
- Inquire about the nine symptoms of major depression.
- Ask five questions to evaluate suicidality.
- Demonstrate empathic interactions with depressed patients.

Key Principles:
- Depressed affect is common, but clinically significant depression is a serious medical condition that requires focused communication skills to manage appropriately.
- All patients with clinically significant depression must be assessed for suicidality.
- Specific communication skills help clinicians to respond to depressed affect; to manage stigma, negative health beliefs and resistance; and to collaborate in negotiating effective treatment strategies.
Pre-session: Conviction and Confidence:

How **convinced** are you that effective communication with depressed patients is an essential clinician competency?

(0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10

How **confident** are you that you can effectively communicate with patients who have depression?

(0 = not at all; 10 = totally)

0  1  2  3  4  5  6  7  8  9  10
Post-session: Conviction and Confidence:

How convinced are you that effective communication with depressed patients is an essential clinician competency?  
(0 = not at all; 10 = totally)

How confident are you that you can effectively communicate with patients who have depression?  
(0 = not at all; 10 = totally)

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Domestic Violence - DocCom Module 28

Facilitator Guide

This module applies to both males and females; however, the majority of domestic violence occurs against women.

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
  o Understand the prevalence of domestic violence in clinical practice and its impact on patients and families.
  o Be aware of the multiple ways domestic violence affects how patients present to their practitioners.
  o Understand the principles of helping patients move from victim to survivor of abuse.
  o Know how to respond appropriately to patients when you uncover domestic violence.
  o Know which actions/interventions may worsen the situation and help patients avoid them.
  o Know community resources and how to use them for your patients who may be in domestic abuse situations.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
  o Inquire about learner’s prior experience: Ask learners about experiences with patients suffering domestic violence. “How did the topic arise?” or “How did you feel addressing this area?” or “How well do you think you met the patient’s needs?”
  o Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
  o Personal experience: If there is time and you have a vivid example from your clinical experience, share that story.

Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can then discuss their answers in groups of 2-3 for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
  o Have you known anyone who has been a victim of domestic violence? What was helpful to them? What were their fears?
  o Have you encountered a patient who suffered domestic violence? How did you feel in the encounter?
  o Have you encountered the partner of a patient who suffered domestic violence? How did you feel about the partner?
Skills Development: (25 min) Show VIDEO: Module 28: Counseling/Video Example: start about 1:45 minutes, play to about 4:45 minutes. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- Debrief Video Exercise: (5 min) “What skills were demonstrated that would be easy for learners to adopt?” or “Which skills would be more difficult?”
- Role Play: Ask learners to pair up (or do role play in front of the group). One learner will play a patient who has suffered domestic violence and the other will play the clinician role. The learner with the domestic violence role might remember one of his/her own patients or make one up. The clinician should engage the patient from the beginning of a typical encounter, attempting to progress through the relevant behavior checklist. Allow three to five minutes, and then ask the clinician to do a self-critique and allow the patient to give constructive feedback. After about five minutes of discussion, learners can switch roles and repeat the process. Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc. Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask for help from other participants. You might interrupt the role play at the two minute mark to tell the learner how he or she is feeling as the patient and to suggest fruitful next steps.
- Debrief: (5 min) Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.

Conclusion/Next Steps: (5 min) Ask learners to complete the handout items, provide assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 29: Alcohol: Interviewing and Advising. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

ASK ABOUT:
- directly about abuse
- duration, pattern of abuse
- severity of abuse
- immediate safety
- thoughts and feelings
- childhood history of abuse
- child abuse
- mood
- substance abuse

SAY:
- “This is wrong.”
- “It’s not your fault.”
- “You don’t deserve this.”
- “You are not alone.”
- “You have a choice.”

DO NOT:
- assign blame
- tell her to leave
- suggest couples counseling

DO:
- empathize, offer understanding
- suggest referral for counseling
- assure her of your respect and your willingness to work with her to make sensible choices for her life
Domestic Violence- DocCom Module 28

Learner Handout

Rationale: Domestic violence is widespread among women seeking medical care. It affects women’s overall well-being, any children involved and society (by increasing cost of health care). As clinicians, there is much that we can do: we can help by screening for abuse, empowering and educating the victims and referring them to specialized domestic violence counselors.

Learning Goals: At the completion of this session you will be able to:
- Understand the prevalence of domestic violence in clinical practice and its impact on patients and families.
- Be aware of the multiple ways domestic violence affects how patients present to their clinicians.
- Understand the principles of helping patients move from victim to survivor of abuse.
- Know how to respond appropriately to patients when you uncover domestic violence.
- Know which interventions may make the situation worse and help patients avoid them.

Key Principles:
- Domestic abuse is common and often missed in clinical practice.
- Abuse victims rarely present with complaints of abuse, but often have many somatic complaints or a history of injuries.
- Abused patients often have severe associated psychological problems.
- Domestic abuse is equally common throughout all socioeconomic classes, cultures and races.
- The clinician’s words are critical in moving patients from being victims to survivors of abuse. The key is empowering patients rather than telling them what to do.
- Understanding each patient’s unique situation is critical to therapeutic planning.
- Multidisciplinary approaches work best.
- Helping patients overcome abuse may take months or years.
Pre-session: Conviction and Confidence:

How convinced are you that skillful interviewing of patients who may suffer from domestic violence is an essential clinician competency? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can effectively address patients who have suffered domestic violence? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10
Post-session: Conviction and Confidence:

How **convinced** are you that skillful interviewing of patients who may suffer from domestic violence is an essential clinician competency? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **confident** are you that you can effectively address patients who have suffered domestic violence? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Alcohol: Interviewing and Advising - DocCom Module 29

Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
- Demonstrate strategies and skills for assessing alcohol use.
- Describe differences between alcohol dependence, alcohol abuse, at risk drinking and moderate drinking (below the NIAAA safe limits).
- Demonstrate strategies and skills for asking questions; advising and negotiating plans that minimize patient’s defensiveness.
- Demonstrate strategies and skills for Brief Interventions that are appropriate both to the severity of the alcohol use disorder and the patient’s interactive style.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
- Inquire about learners’ prior experience: Ask learners about experiences with patients with alcohol use disorders. “How did the topic arise?” or “Were you able to classify the patient’s disorder?” or “How effectively did you deal with the patient’s denial?”
- Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
- Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: how you were involved in helping someone get into sustained recovery and what that meant to you; or a positive insight you gained from interacting with a patient around alcohol use problems.

Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can then discuss their answers in groups of 2-3 for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
- How have you been affected by family, friends, or patients with alcohol problems? How will your feelings about these experiences affect your interactions?
- Thinking about your interviews with patients with alcohol problems, can you recall moments when you treated them less professionally than you would wish?
- Ample evidence exists that dependent people cannot always exert full control over their intake. What shapes your attitudes about whether you fully accept this evidence?
- Patients whose lives are falling apart because of alcohol often do not accept help or suggestions from you. How do you feel about this?
Skills Development: (25 min) Show VIDEO: Module 29: Further Assessment/Video Pro-Con/start about 1:45 minutes, stop at about 4:50 minutes. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- **Debrief Video Exercise:** “What skills were demonstrated that would be easy for learners to adopt?” or “Which skills would be more difficult?”
- **Role Play:** Ask learners to pair up (or do role play in front of the group). One learner will play a patient with any level of alcohol use disorder and the other will play the clinician role. The learner with the alcohol problem role might remember one of his/her own patients or make one up. The clinician should engage the patient from the beginning of the part of the encounter where it is appropriate to begin inquiring about alcohol use, attempting to progress through the relevant behavior checklist. Allow three to five minutes, and then ask the clinician to do a self-critique, and allow the patient to give constructive feedback. After about five minutes of discussion, learners can switch roles and repeat the process. Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc. Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask for help from other participants. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.

- **Debrief:** (5 min) Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.

**Conclusion/Next Steps:** (5 min) Ask learners to complete the handout items, provide the assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

**Next Session Assignment:** Read DocCom Module 30: Drug Abuse Diagnosis and Counseling. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

1. Screening
   o Say that inquiry about alcohol use is part of your routine for providing quality healthcare.
   o Ask whether patients sometimes drink alcohol.
   o Screen with “how many times in the past year have you drunk 5 or more drinks in a day (men) or 4 or more drinks in a day (women or people over 65).”

2. Assessment
   o Follow up positives (from screening or other clues) with questions -- Have you ever Cut down on your drinking? Have you ever been Annoyed by criticism of your drinking? Have you ever felt Guilty about your drinking? Have you ever had an Eye Opener in the morning? (CAGE).
   o Determine a weekly total of drinks.
   o If CAGE is positive or any clue is present, ask about consequences and symptoms:
     o Psychosocial symptoms (relationship, job or legal problems, role failure, other drug use, depression, anxiety).
     o Alcohol-specific consequences (blackouts, arrests for DUI/OUI/DWI, AA attendance, family history).
     o Alcohol-specific symptoms (tolerance, withdrawal, difficulty with control or cutting down, preoccupation, continued use despite consequences).
     o Somatic symptoms (heartburn, trauma, insomnia).
   o Caring words and gestures—respond to patient’s distress signals of irritability, hostility, anxiety or defensiveness with empathy.
   o Persist with screening or probing questions in spite of patient’s vagueness, defensiveness or distractions.
   o While gathering information, refrain from advising, from offering to fix potential problems, from “setting the patient straight” about misconceptions or from talking about treatment options.
   o Assess readiness to change (conviction) and confidence about changing.
   o Ask patient to examine the pros and cons of drinking and changing.
   o Make a verbal transition to planning and assisting.

3. Advise and Assist
   o Perform a brief intervention appropriate to patient’s readiness to change.
   o Use “ask-tell-ask” strategy to give information and check understanding.
   o Appreciate patient’s strengths; support self-efficacy.
   o Support autonomy and choice.
   o Reflect ambivalence about change back to patient.
   o Create an objective climate; discuss facts not conclusions.
   o “Tell” (Educate) about: healthy drinking, labels (diagnosis), pathophysiology (in lay terms), withdrawal, treatment.
   o “Tell” (Negotiate) a drinking goal for patients with at-risk alcohol use.
   o “Tell” (Advise) abstinence for patients with abuse or dependence.
   o “Tell” (Refer) patients with alcohol abuse or dependence to a comprehensive treatment program: Alcoholic
   o Anonymous or other local facilities.
   o Use conviction/confidence ruler to calibrate agreement.
   o Create dialogue.
   o Create an objective climate.
   o Feedback facts, not conclusions.
Alcohol: Interviewing and Advising - DocCom Module 29

Rationale: Alcohol use disorders are sometimes occult in clinical practice. But they afflict 20 percent or more of adults, leading to tragic family and social problems, preventable injuries and death. Most clinicians feel inadequately prepared to interact with these patients and many express feelings of dismay, anger or outright disgust at having to do so. Effective assessment tools improve detection and brief counseling interventions not only reduce drinking and improve health, but improve clinicians’ satisfaction with their encounters.

Learning Goals: At the completion of this session you will be able to:
  o Demonstrate strategies and skills for assessing alcohol use.
  o Describe differences between alcohol dependence, alcohol abuse, at risk drinking and moderate drinking (below the NIAAA safe limits).
  o Demonstrate strategies and skills for asking questions; advising and negotiating plans that minimize patient’s defensiveness.
  o Demonstrate strategies and skills for Brief Interventions that are appropriate both to the severity of the alcohol use disorder and the patient’s interactive style.

Key Principles:
  o Alcohol use problems exist on a continuum. Alcohol dependence is on the severe end and at-risk alcohol use at the mild end, with alcohol abuse in between.
  o Effective clinicians know the NIAAA safe (moderate) drinking limits and talk with patients about them.
  o Persons with alcohol use disorders consistently minimize and cover up alcohol problems (both consciously and unconsciously). Use a structured strategy of screening and pursuit of clues.
  o Many serious alcohol problems are obvious to clinicians, but we delay action because intervention may be unsettling and painful.
  o Target brief interventions to patient’s readiness for change.
  o To improve the effectiveness of brief interventions, give clear and direct advice in a relationship centered, empathic and compassionate way that avoids a confrontational style.
  o Learn and use specific skills to help hostile, denying and ashamed patients who feel helpless and hopeless.
Pre-session: Conviction and Confidence:

How **convinced** are you that assessing and advising patients with alcohol problems is an essential clinician competency?  
(0 = not at all; 10 = totally)

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How **confident** are you that you can effectively assess and advise patients with alcohol problems?  
(0 = not at all; 10 = totally)

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Post-session: Conviction and Confidence:

How **convinced** are you that assessing and advising patients with alcohol problems is an essential clinician competency?  
(0 = not at all; 10 = totally)

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How **confident** are you that you can effectively assess and advise patients with alcohol problems?  
(0 = not at all; 10 = totally)

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What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
**Drug Abuse: Diagnosis and Counseling DocCom Module 30**

**Facilitator Guide**

**Check-in:** (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

**Self-assessment:** Ask learners to mark pre-session conviction and confidence scales. (handout)

**Session Goal Setting:** Inform your group members of the following goals:
- Delineate the interviewing skills necessary to screen effectively for substance use and abuse.
- Demonstrate skills for evaluating patient’s readiness to accept the diagnosis and readiness to undertake behavior change.
- Clearly and supportively recommend treatment to patients with substance use disorders.
- Define the skills that help set respectful limits on patient requests for prescription medication.
- Demonstrate knowledge of substance use disorder treatment standards and the ability to recommend appropriate referrals.

**Personalized Goal Setting:** Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

**Engaging Learner Interest/Discussion:** (10-15 min)
- Inquire about learners’ prior experience: Ask about learners’ experiences with substance-using patients: “What are some of the barriers?” or “What successes have they had and what made them successful?”
- Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
- Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: how you were involved in helping someone get into sustained recovery and what that meant to you or a positive insight you gained from interacting with a patient around substance use problems.

**Personal Reflection:** (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can discuss their answers in groups of two to three for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
- How have your experiences with patients, family members, friends and colleagues with substance use disorders affected your attitudes towards substance-using patients?
- What reservations do you have about accepting the disease model for substance use disorders? Why do clinicians often fail to ask substance use screening questions?
- Describe how you feel when your patients fail to curb their substance use or even acknowledge interest in doing so?
- Clinicians often tell patients, “You will die if you do not stop using drugs!” or “Your wife says she is leaving unless you change your ways!” What are the implications of this type of communication?
- How do you respond to some patient’s disrespectful, dismissive, irritated or angry responses when asked about substance use? What behaviors are most likely to “push your buttons,” so that your responses are not therapeutic?
- Can you say “no” when patients you respect and care for over long periods of time request prescriptions for controlled drugs that are not of proven or clear medical value for them, i.e., diazepam or oxycodone for chronic back pain or headache or additional sedatives for insomnia?
**Skills Development:** (25 min) Show short clips from Module 30: “Patient Interview” section. We recommend showing the Q19 clips (“What was your experience when you interacted with clinicians as a substance abuser?”) for Rhonda, Cliff and George, but you may prefer others. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- **Debrief Video Exercise:** “What skills that would be easy to learn might he/she use in talking with patients similar to those in the video and what skills might be more difficult to use/learn?”
- **Role Play:** Ask learners to pair up (or do role play in front of the group). One person will play a patient and the other the clinician. Ask learners to choose and specify one or more skills from the checklist to work on and get feedback about. We suggest a “screening” scenario in which the married, working, middle class, insured man or woman is using marijuana, alcohol and cocaine and comes in for shoulder tendonitis from too much gardening. The shoulder history has been taken and it is time for a few psychosocial context questions. Patient declares “social drinking” and you are to follow up with the CAGE-AID questions.
  - Alternatively, imagine that the above patient has acknowledged that excess alcohol and marijuana use are harming relationships and role function (as parent, partner or at work). Patient does not disclose cocaine use. Take turns doing a six minute brief intervention. Give each other feedback and discuss.
  - Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask colleagues for help. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.
- **Debrief:** (5 min) Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.

**Conclusion/Next Steps:** (5 min) Ask learners to complete the handout items, provide the assignment for next session and collect handouts. The handout items are:
- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

**Next Session Assignment:** Read DocCom Module 33: Giving Bad News. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

1. Screen every patient for drug use with structured questions, such as the CAGE-AID.
2. Follow up positive screens or “red flags” by assessing details of drug use and consequences of use.
4. Show non-judgmental, empathic verbal and non-verbal behaviors during screening, evaluation and intervention conversations.
5. Obtain the patient’s perspective on current and potential consequences of his/her drug use.
6. Conduct a brief intervention.
7. Inform the patient about the potential impact of substance use on health, family, employment, mental health and well-being.
8. Inform the patient clearly and succinctly about treatment options and make referrals for treatment.
9. Demonstrate your willingness to provide continuing care to patient with substance use disorders.
10. Communicate with the patient’s family.
11. Inform the patient about the role of drug and alcohol testing in treatment monitoring.
12. When recommending treatment, communicate the following points to the patient:
   o Individual needs vary and treatment consists of psychological, social, vocational and biological interventions. Treatment programs assess these needs, organize interventions and monitor all aspects of treatment and recovery.
   o Referral to addiction specialists is vital. Visits to other practicing clinicians are not treatment.
   o Detoxification is only a first step in treatment for substance use disorders.
   o Medications may be helpful, but never in isolation; therefore, psychoactive drug prescriptions need to be given by a specialist within a broader treatment program.
   o Recovery is a long-term process and it often takes years to return to fully responsible functioning.
   o Reflect on your own responses to patient with substance use disorders.
Rationale: Most clinicians could improve their care of substance-use patients by adhering to the “disease model” in their relationships with such patients and employing a few special skills. Clinicians seem to “give up” on patients with serious substance use disorders and seem disinclined to attempt to discover substance use disorders in patients who are less obviously affected. We fail to understand the meaning and importance of somatic and emotional cues given by people who hide their substance use or lie about it. Too often, we fail to make a diagnosis and fail to engage in respectful brief interventions about how the substances and addiction work in the brain, about the normal complexity and resistance to stopping substance use and the availability of both professional treatment and mutual help programs.

Learning Goals: At the completion of this session you will be able to:
   - Describe the essential components of the medical model of substance use disorders.
   - Delineate the interviewing skills necessary to screen effectively for substance use and abuse.
   - Clearly and supportively recommend treatment to patients with substance use disorders.
   - Define the skills that help set respectful limits on patient’s requests for prescription medication.

Key Principles:
   - Substance use disorders affect 45 percent of patients who present for medical care but are routinely unrecognized by healthcare clinicians.
   - Clinicians can play a key role in facilitating the diagnosis and treatment of patients with substance use disorders.
   - The use of structured screening and assessment strategies (i.e. CAGE Questionnaire) is essential in the assessment of substance use disorders.
   - Staging the severity of addiction, calibrating patient’s readiness to change behaviors and willingness to access professional help is crucial to good medical care.
   - Sustained recovery requires many resources. To achieve treatment goals, clinicians should become comfortable referring patients to resources such as self-help groups, professional treatment programs and psychiatrists to treat co-morbid psychiatric disorders.
Pre-session: Conviction and Confidence:

How **convinced** are you that recovery from substance use disorders requires more than will power and more help than you can provide in office or hospital? \(0 = \text{not at all}; 10 = \text{totally}\)

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How **confident** are you that you can say “no” to prescribing mood altering drugs to people with substance use disorders, explain your rationale in an empathic manner and sensitively recommend treatment programs and mutual help programs to such patients? \(0 = \text{not at all}; 10 = \text{totally}\)

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Post-session: Conviction and Confidence:

How **convinced** are you that recovery from substance use disorders requires more than will power and more help than you can provide in office or hospital? *(0 = not at all; 10 = totally)*

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How **confident** are you that you can say “no” to prescribing mood altering drugs to people with substance use disorders, explain your rationale in an empathic manner and sensitively recommend treatment programs and mutual help programs to such patients? *(0 = not at all; 10 = totally)*

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What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?

*When asked about working with patients with substance use disorders, clinicians make comments like these: “substance use disorders are not my domain,” “they’ll never stop,” or “they don’t listen.” “The lying, the denying, the rejection of helpful advice and their attitudes (of ‘yes, yes,’ or ‘no, never, leave me alone’) are too hard to work with.”*
Giving Bad News - DocCom Module 33

Facilitator Guide

Check-in: (5 min) Ask questions like: “What's happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
- Describe the effects (on patients and on clinicians) of clinicians’ empathic responses to strong emotions, as well as the effects of ignoring strong emotions.
- Identify likely origins of strong emotions.
- Describe how clear personal boundaries promote clinical effectiveness and professional growth.
- Demonstrate ability to respond empathically to strong emotions.
- Describe situations that may require referral or medication as adjunctive responses to strong emotions.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (10-15 min)
- Inquire about learners’ prior experience: Ask learners to describe a time when they gave (or observed giving) bad news well. “What skills helped it go well?” or “Have they observed or been involved when it has not gone well?”
- Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
- Personal experience: If there is time and you have a vivid example from your clinical experience, share that story.

Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can discuss their answers in groups of two to three for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.
- How do you feel when you need to tell someone bad news?
- What have been your reactions or your family’s reactions when you have heard bad news in the past?
- What might the bearer of bad news do to help you hear it and absorb it?
- What makes the communication of bad news go well? What makes it go poorly? From whose standpoint are you answering this question?
- When delivering bad news, how can you take care of yourself while attending to the needs of your patients and their families?
- What are your fears about illness and death? How might these fears affect your communication of bad news?
Skills Development: (25 min) Show VIDEO: M 33, You Have Cancer. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- **Debrief Video Exercise:** “What skills were demonstrated that would be easy for learners to adopt?” or “Which skills would be more difficult?”
- **Role Play:** Ask learners to pair up (or do role play in front of the group). Quickly develop a scenario, find a cue line and do a three to five minute role play, with a focus on skills in the Behavior Checklist. Provide positive feedback/suggestions. Repeat as time allows. You might consider the following points for scenario development:
  - Around this topic, what would be the issues for you?
  - Can we use a scenario you have faced in the past or the sort of thing you often have to do?
  - What do we need to know to make the scenario real for you?
  - Establish sufficient detail so participants can get into role.
  - What are your learning objectives for this scenario?
  - What would you like to get feedback on?
  - Consult the Behavior Checklist.
  - Remember, interviewer can ask for time out any time and may change roles any time. Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask colleagues for help. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.
- **Debrief:** (5 min) Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.

Conclusion/Next Steps: (5 min) Ask learners to complete the handout items, provide the assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

**Next Session Assignment:** Read DocCom Module 34: Communicating with Patients Near the End of Life. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

Verbal Behaviors
- Ask what the patient and family already know and what they expect.
- Ask before telling.
- Use a “warning shot,” such as, “I do not have good news.”
- Use simple, straight-forward language.
- Give the patient and family time to respond to each piece of information.
- Acknowledge, legitimize and explore strong emotion before reassuring or moving on.
- Describe a range of time when communicating prognosis; allow for exceptions.
- Because patient and families don’t hear much after the initial diagnosis, repeat key data during both the initial conversation and follow ups.
- Establish a concrete plan for immediate next steps.
- Assure the patient and family that you will make certain they are not abandoned.

Non-verbal behaviors
- Find a private space and uninterrupted time.
- Sit down, shake hands and check in with patient and family.
- Listen carefully to the verbal responses and observe carefully the nonverbal responses.
- Allow silence.
- Have tissues handy.
Giving Bad News - DocCom Module 33

Learner Handout

**Rationale:** Breaking bad news is a frequent task in clinical practice. It can be challenging and emotionally difficult for the clinician, as well as the patient. Patients remember the breaking bad news conversation for the rest of their lives and there is evidence that the conversation affects patient’s mental health and coping for many months afterwards. There is much research that demonstrates that clinicians often break bad news badly. There is fair agreement among experts on the essentials of bad news delivery. By learning and following the essential steps you can communicate bad news effectively and compassionately.

**Learning Goals:** At the completion of this session you will be able to:
- Describe the six-step protocol for delivering bad news.
- Name four ways of responding to the feelings of a patient receiving bad news and give an example of each.
- Name four common barriers or pitfalls in delivering bad news.
- Demonstrate the ability to deliver bad news using the six-step protocol.

**Key Principles:**
- “Bad” news is defined by the person receiving the news.
- Communicating bad news is a core clinical skill and the quality of your bad news communication has a powerful impact on every other aspect of your clinical relationships.
- The quality of bad news delivery is strongly affected both by clinicians’ feelings (especially by negative feelings) and by their competence in responding with empathy to their patient’s reactions.

**A Six Step Protocol:**
- Preparation and planning
  - What does the patient want to know?
  - How much does the patient want to know?
- Sharing the information
- Responding to emotions
- Planning and follow-up
**Pre-session: Conviction and Confidence:**

How **convinced** are you that it is important to use the six step protocol in giving bad news? *(0 = not at all; 10 = totally)*

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How **confident** are you that you can give bad news in an organized and compassionate way that is helpful to your patient? *(0 = not at all; 10 = totally)*

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Post-session: Conviction and Confidence:

How convinced are you that it is important to use the six step protocol in giving bad news? (0 = not at all; 10 = totally)

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How confident are you that you can give bad news in an organized and compassionate way that is helpful to your patient? (0 = not at all; 10 = totally)

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What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Communicating with Patients Near the End of Life –
DocCom Module 34

Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
   - Communicate effectively and compassionately with patients near the end of life.
   - Discuss prognosis openly and accurately.
   - Engage in dialog about your patient’s goals of care.
   - Suggest limitations of care that are consistent with your patient’s goals.
   - Refer patients to hospice at the appropriate time.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (20 min)
   - Module review: ask about the main insights they had from reviewing Module 34. Review the most interesting points from their replies and from their answers to multiple choice questions and discussion questions. Ask what communication skills they saw the clinician use in the videos that seemed most effective.
   - Inquire about learners’ prior experience: Ask learners to volunteer to relate an experience with a dying patient, what went well and what was difficult for them. Facilitate a discussion with the learners about these experiences, mainly allowing the learners to respond to each other.
   - Personal experience: If you have a compelling experience that shaped the way you communicate with patients near the end of life, it can be helpful to share that after learners have offered their own perspectives.
Skills Development: (20 min) Show VIDEO: M 34, “with husband” Play initial 5 minutes. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.

- **Role Play:** Ask learners to pair up (or do role play in front of the group). One learner will play a patient and the other the clinician, discussing end of life care. You can ask a learner to role play a recent patient with a terminal illness or give instructions about a patient role. The patient role can be a patient in his/her late 50s whom you’ve been treating for about five years with hypertension, metabolic syndrome and mild COPD from 40 years of smoking. The patient came in with new onset dyspnea on exertion and you heard decreased breath sounds and found a flat percussion note about half-way up the right lobe about a month ago. A subsequent work up revealed a malignant pleural effusion from small cell lung cancer, with mets to the liver and adrenals. An oncologist started chemo two weeks ago, which has had severe side effects, including nausea and vomiting, fatigue and some light headedness. The patient comes in today to recheck his/her HT, sugar, and to talk about the cancer diagnosis and your opinions about how to proceed. He/she was told that he/she had about six months to live by the oncologist. This is the first visit to the PCP since starting the chemo.
  - Ask the learner playing the clinician to articulate the communication goals for the visit, and some of the words he/she will use, before starting the role play.
  - Another approach to role play is to play the patient yourself and ask a learner to be the clinician in the scenario above. The learner can ask for time outs, if necessary, and ask colleagues for help. You might interrupt the role play at the two minute mark to tell the learner how you are feeling as the patient and to suggest fruitful next steps.

- **Debrief:** Allow the role play to go five minutes maximum and then have a general discussion. Ask the clinicians what he or she did well, what they had difficulty with and why. Ask the patients how the communication landed and what else they would have wanted the clinicians to say.

Conclusion/Next Steps: (10 min) Ask learners to complete the handout items, provide the assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

Next Session Assignment: Read DocCom Module 40: Providing Effective Feedback. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
Rationale: Many patients nearing the end of life are frightened and worry that they will be abandoned. Clinicians may overcome their own sense of hopelessness and helplessness and relieve considerable suffering through directed interventions and compassionate communication. Clinicians often feel they have little to offer patients near the end of life. Perhaps the patient with metastatic cancer has failed his third round of chemotherapy or the patient with left main coronary artery disease is ineligible for bypass surgery because of his compromised medical status. Perhaps the patient with dementia responded to treatment of her aspiration pneumonia but then aspirated again a week later. The clinician may feel helpless in the face of the approaching end of life but in fact he/she has a great deal to offer. Many patients feel even more helpless, hopeless, isolated, frightened and in pain. They turn to their clinician for help in the physical, psychological and spiritual domains. End-of-life care is a critically important, labor-intensive form of medical care. Clinicians must be able to communicate their ability to relieve suffering and assure patients that they will not be abandoned.

Learning Goals: At the completion of this session you will be able to:
  - Communicate effectively and compassionately with patients near the end of life.
  - Discuss prognosis openly and accurately.
  - Engage in dialog about your patient’s goals of care.
  - Suggest limitations of care that are consistent with your patient’s goals.
  - Refer patients to hospice at the appropriate time.

Key Concepts:
  - Patients and families highly value your attentive communication.
  - Many patients wish to discuss their diagnosis and prognosis.
  - When your patients near the end of life, you must offer to discuss their priorities in order to develop a meaningful plan of care.
  - Good end-of-life care often requires hospice services and your referrals need to be both skillful and compassionate.
**Pre-session: Conviction and Confidence:**

How **convinced** are you that it is important for you to engage patients in discussion about their perspective, goals and values as they near the end of life? *(0 = not at all; 10 = totally)*

```
0   1   2   3   4   5   6   7   8   9   10
```

How **confident** are you that you can have frank and compassionate discussions about end of life care and decision making with your patients and their families? *(0 = not at all; 10 = totally)*

```
0   1   2   3   4   5   6   7   8   9   10
```
Post-session: Conviction and Confidence:

How convinced are you that it is important for you to engage patients in discussion about their perspective, goals and values as they near the end of life? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can have frank and compassionate discussions about end of life care and decision making with your patients and their families? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Giving Effective Feedback (Creating an Optimal Learning Environment)
- DocCom Module 40

Facilitator Guide

Check-in: (5 min) Ask questions like: “What’s happening?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

Self-assessment: Ask learners to mark pre-session conviction and confidence scales. (handout)

Session Goal Setting: Inform your group members of the following goals:
- Describe characteristics of a learning environment that facilitates and encourages feedback.
- Describe general feedback principles.
- Describe the problems associated with giving effective feedback and how to overcome them.
- Describe the general principles and specific strategies you can use to create an optimal learning environment for learners.

Personalized Goal Setting: Ask what specific skills from the Behavior Checklist each learner wants to improve for him/herself. (Write these on the board or easel.)

Engaging Learner Interest/Discussion: (20 min)
- Inquire about learners’ prior experience: Ask about their experiences giving and receiving feedback. “Who had an effective and helpful experience receiving feedback and what made it so?”
- Module review: Ask about the main insights they had from reading Module 40. Review the most interesting points from their replies and from their answers to multiple choice questions and discussion questions.
- Personal experience: If you have a compelling experience with giving or receiving feedback that shaped the way you give feedback, it can be helpful to share that after learners have offered their own perspectives.
- Next, discuss the guidelines handout. “What points did they find particularly useful?” or “How many of these strategies did they experience in their training so far?” or “What did the best learners do to enhance their learning?” or “What did learners do that was unhelpful and that they will not do when they are leading a team?” or “What gets in the way of using some of the strategies in the handout?” or “How can the barriers be overcome?” Discuss the essential components of giving and receiving feedback. Ask about the way one should receive feedback. (Some guidelines for receiving feedback: Be open to learning; consider that the person giving the feedback is trying to contribute to you; listen carefully; breathe; suppress the urge to be defensive; ask clarifying questions; acknowledge the feedback.)

Skills Development: (20 min) Show VIDEO: Module 40: TV- Learner feedback. This video runs about five minutes. You may wish to pick a three-minute segment. While watching the video and using the Behavior Checklist, each learner should identify at least five skills demonstrated by the clinician in the video.
- Sometimes a learner in the group will be able to discuss a situation that he/she encountered with an ineffective or negative learning environment. The learner can tell enough of the situation so that you can facilitate doing a role play in which the learner can give feedback to the learner or attending in an effort to correct the situation.
Conclusion/Next Steps: (10 min) Ask learners to complete the following pages on handout:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)

See GUIDELINES FOR LEARNERS – attached to “Learner handout”
Rationale: Giving effective feedback facilitates learning and can be essential in improving teamwork and patient care. You can learn to make your feedback more effective by paying attention to certain principles and using certain communication strategies.

Learning Goals: At the completion of this session you will be able to:
  o Describe characteristics of a learning environment that facilitates and encourages feedback.
  o Describe general feedback principles.
  o Describe the problems associated with giving effective feedback and how to overcome them.
  o Describe the general principles and specific strategies you can use to create an optimal learning environment for learners.

Key Concepts: Effective feedback from faculty and peers facilitates improvement and learning. A safe and effective culture of feedback includes the following features:
  o agreement on learning goals
  o consensus about expectations
  o direct observation of behaviors
  o consideration of emotions
  o checking learners’ understanding and commitment to continued improvement
  o invitation to reflect on potential personal and system resistance to utilization of feedback
  o there are defined principles and strategies that can help facilitate an optimal learning environment
Professionalism: Boundary Issues - DocCom Module 41

Facilitator Guide

**Check-in:** *(5 min)* Ask questions like: “What’s happening in your lives?” or “What do we have to do to clear the air so we can begin the session?” or “Do you have any major stressors?”

**Self-assessment:** Ask clinicians to mark pre-session conviction and confidence scales. (handout)

**Session Goal Setting:** Inform your group members of the following goals:
- Describe ‘boundary-challenging’ situations that clinicians commonly encounter.
- In individual and group settings, reflect on appropriate boundary limits for clinicians, in general, and yourself personally.
- Describe strategies for deciding how to respond to commonly encountered ‘boundary-challenging’ situations.
- In ‘boundary-challenging’ situations, demonstrate ability to compassionately appeal to professional standards; state a general principle to which you adhere; clarify the nature of the relationship or postpone a decision.

**Personalized Goal Setting:** Ask what specific skills from the Behavior Checklist each resident wants to improve for him/herself. (Write these on the board or easel.)

**Engaging Learner Interest/Discussion:** *(10-15 min)*
- Inquire about clinicians’ prior experience: Ask about their experiences with boundary challenges: “Have they experienced emotional reactions to patients, such as a strong like or dislike, or the feeling that they are saying or doing things around a particular patient that they wouldn’t normally say or do?” or “Have they confronted or avoided these challenges and why?” or “Have they designed an ‘alarm’ system?” or “What successes have they had and what made them successful?”
- Module review: Ask what they found most useful in the module, either about the conceptual framework or the specific communication skills presented.
- Personal experience: If there is time and you have a vivid example from your clinical experience, share that story: how facing a boundary challenge with a patient made a big difference in your relationship or an insight you gained from failing to confront a boundary challenge.
Personal Reflection: (A useful exercise, if you have time) Ask learners to jot down answers to these questions. If you have a large group, they can then discuss their answers in groups of 2-3 for 15 minutes and then share their contributions and insights with the larger group. Otherwise, you can conduct a group discussion.

- What elements distinguish a professional relationship from other human relationships such as friendship, family or that between colleagues or classmates?
- In your professional relationships to date (as clinician or as patient or as family member of a patient) have you been aware of situations when the professional person responded in ways that did not seem appropriately “professional” (perhaps by behaving in too social or friendly a manner or perhaps by seeming too distant or abrupt)? How do these experiences inform your sense of “professionalism”?
- In a clinical situation, what principles might be useful in deciding how to respond to gifts you are offered from patients or to a possible “come-on” from a patient or to patients’ questions about your personal life?
- Have you encountered situations in which your professional boundaries became an issue? How did you decide what actions to take?
- Personal issues play a role in clinician’s behaviors in regard to professional boundaries. How do the following issues apply to you?
  - To what degree do you take responsibility for the happiness and well-being of your patients? Of your family and friends?
  - To what degree are your interactions with patients meeting your own emotional needs?
  - How comfortable are you in saying “no” to patient requests?
  - Are you prone to “rescue fantasies” in your care of patients?
  - Do you often take care of the needs of others before your own?
  - What were the attitudes and behaviors about boundaries in your family of origin?

Skills Development: (25 min) Show VIDEO: Module 41: Challenges/click on the initial video in each of the sections – “Self disclosure; Gift giving; Social invitation.”

- Debrief Video Exercise: What skills described in Module 41 text might be utilized in response to these triggers?
- Role Play: Ask learners to pair up (or do role play in front of the group). One learner will play a patient and the other the clinician. Ask them to practice responding to offers, personal invitations or questions about personal matters using the types of responses in the Checklist below. Suggest that the person in the clinician role imagine his/her partner to be a patient with traits (needy, hostile, etc.) or characteristics (age, gender, profession, etc.) that he/she knows or suspects might pose boundary issues for him/her. (No need to disclose these traits or characteristics if disclosure would be difficult in any way.) After five to seven minutes, change roles.
- Debrief (5 min): Allow five minutes at the end of this segment to have a general discussion about what worked, what were the barriers, etc.; address the goals or issues that were listed as initial goals. Include an invitation to reflect on moments in the exercises or in their work when their “boundary alarm” went off or “should have” warned them.

Conclusion/Next Steps: (5 min) Ask clinicians to complete the handout items, provide assignment for next session and collect handouts. The handout items are:

- Conviction and confidence post-session scales
- A skill they plan to practice in the coming week in their clinical work
- What else they learned in the session today
- What you might do to improve a future session (feedback)
Next Session Assignment: Read DocCom Module 27: Communicating with Depressed Patients. Complete the multiple choice questions and respond to one of the questions in Discussion Question 2.
BEHAVIOR CHECKLIST

When encountering a boundary challenge:
- Appeal to medical ethics or professional standards.
- Appeal to general principles.
- Reiterate the nature of the relationship.
- Take the time you need to consider an issue. Think for a moment about your emotional reactions (attraction, feeling manipulated, confused) and how you need to respond to the reactions in a way that is helpful to the patient.
Professionalism: Boundary Issues - DocCom Module 41

Learner Handout

Rationale: The clinician-patient’ relationship requires a special kind of intimacy. Caring and warmth must be shared within mutually understood professional boundaries, and “boundary challenges,” such as offers of gifts, social encounters or personal questions arise regularly in clinical practice. The “boundary alarm” framework is a useful conceptual guide for negotiating boundaries in clinical practice. Like a home security system, a “boundary alarm” functions to preserve safety, well-being and integrity. Each clinician must set his/her alarm to ring at the correct threshold - a setting that is too low produces cold and distant relationships, while too high a setting may result in unprofessional behavior and unsafe outcomes. Awareness of boundary challenges and responses to them that are simultaneously human and professional require both mindfulness and skills practice.

Learning Goals: At the completion of this session you will be able to:
  o Describe “boundary-challenging” situations that clinicians commonly encounter.
  o Reflect on your own emotional reactions to boundary challenges, especially about how your inner thoughts and feelings might affect your responses to the patient.
  o In individual and group settings, reflect on appropriate boundary limits for clinicians, in general, and yourself personally.
  o Describe strategies for deciding how to respond to commonly encountered “boundary-challenging” situations.
  o In “boundary-challenging” situations, demonstrate ability to compassionately appeal to professional standards, state a general principle to which you adhere, clarify the nature of the relationship or postpone a decision.

Key Principles:
  o “Boundary-challenging” interactions are those in which optimal professional action is unclear, often because the distinction between social and professional behavior is hazy.
  o Every clinician faces “boundary-challenging” situations such as gift-giving, self-disclosure, physical touching, social invitations or social encounters with patients.
  o Problem-solving requires that clinicians reflect on the value of altruism, consider patient and clinician motives, take into account inherent power differentials, seek consultation and err on the side of firm boundaries.
  o Communication about boundaries should convey respect for patients’ feelings and also acknowledge the complexity of the situation. Appropriate statements often mention ethical and professional standards, clarify the professional nature of clinical relationships or indicate the clinicians’ need for additional time to consider the situation.
Pre-session: Conviction and Confidence:

How **convinced** are you that recognizing “boundary-challenging” situations in clinical work is an essential clinician competency? *(0 = not at all; 10 = totally)*

0  1  2  3  4  5  6  7  8  9  10

How **confident** are you that you can talk with patients about the complexity of situations that involve gifts, invitations, touching or social interactions, and simultaneously convey respect for patients’ feelings? *(0 = not at all; 10 = totally)*

0  1  2  3  4  5  6  7  8  9  10
Post-session: Conviction and Confidence:

How convinced are you that recognizing “boundary-challenging” situations in clinical work is an essential clinician competency? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can talk with patients about the complexity of situations that involve gifts, invitations, touching or social interactions, and simultaneously convey respect for patients’ feelings? (0 = not at all; 10 = totally)

0 1 2 3 4 5 6 7 8 9 10

What are two or three main points that you learned in the session today?

What skill do you plan to practice in your clinical work in the coming week?
Guidelines for Residents

Developed by Interns of the Drexel University College of Medicine Internal Medicine Residency Program 2008 - 2010, with Dennis H. Novack, M.D.

Principles:

1. **Golden rule: Treat your interns the way you would want to be treated!** You and your interns are a team and you are equal colleagues/teammates; interns are not subordinates. Remember, you were in their shoes a short time ago. If you can both share and discuss that sense of teamwork, patient care becomes more effective and efficient. (Sometimes interns have done residencies in other countries and have considerable experience. Be open to learning from them.)

2. **Residents have an obligation to teach** both interns and medical students. Please think about what and how you will be most effective at this and spend time preparing to teach. This teaching can be both academic and practical. (Examples of practical points: How to work with talkative patients, how to respond to family members’ concerns, how to decrease patients’ hospital stays, how to prioritize clinical tasks, time management, in general, the “ins and outs” of the system.)

3. **Communication is key.** Keep communication open with your team. If you are unhappy with how some things are going, set aside time to “clear the air;” resentment undermines team dynamics. As team leader, you are an authority figure, and most interns feel reluctant to bring up issues or be assertive about their needs. They probably need your encouragement to talk about how things are going for them and what they need from you.

4. **Perfection is the enemy of the good.** You don’t need to be perfect or expect your interns to be perfect. Saying “I don’t know the answer to that, let’s look it up.” or, “I’m not comfortable managing this problem, let’s get a consult.” can be reassuring to your team members and set a good example.

5. **Provide positive energy!** Your positive attitude and enthusiasm can make a real difference in the team.

6. **You are a role model and a mentor for your team.** Your interaction with patients, colleagues and staff sets an example of professional behavior. Also, you have been through a lot during your internship, and the lessons that you pass on to your interns will be a real help to them. Interns will make mistakes. If you are supportive and understanding, your attitude will reduce anxiety and promote learning.
   a. Encourage questions and requests for help. Let them know it is normal to be unsure of many things and this action will foster their growth and team effectiveness.
   b. In addition to looking for things that are wrong and correcting them for the future, find things that are going right, and compliment your interns for them.
   c. Do not talk disparagingly about other house staff. This amounts to gossip and sets a poor example.
   d. Ask yourself whether your contributions to the culture of learning in the residency program are positive ones?

7. **Monitor feelings and mood.** Since up to 30 percent of house staff suffer burn-out or depression, be sensitive to your own and your team members’ emotional state. If you are irritable and easily annoyed, it diminishes your effectiveness and contributes to a negative learning environment; talk to a colleague or
get other help. If you notice that a team member is down or dragging, find out what’s going on and offer help.

8. **Be an advocate for your team.** Team leaders need to protect team members from inappropriate demands. Take responsibility for the team. (For example, if the attending asks about something that hasn’t been done, don’t blame the intern!)

9. **“Think about what’s best for the patient, not about yourself, and you won’t go wrong.”** (Edgar Sanchez)
   In a way, this principle seems obvious, but sometimes it gets lost when a fellow or attending gets annoyed at you when you call in the middle of the night. You or your intern might feel intimidated to call because of a superior’s negative reputation or you may not want to ask a question for fear of being criticized or that others might think less of you. If you can keep the perspective that we’re here for the patients first of all, and that any potential blows to our self-esteem count for little when compared to the patients’ needs for us to care for them, you’ll do what is right.
**Strategies:**

1. Look at the first day as a team building exercise. Get to know each other. This sets the tone for the whole rotation. Ask your interns how they learn most effectively. What are their expectations and learning goals for this rotation? How can you help them achieve those goals? Do they learn best with a lot of guidance or do they want to work independently and call you when they need you? Come up with an explicit agreement about how you will work together during the month.

2. At the beginning of every rotation, clarify with your interns and students the goals and expectations for the rotation. It is helpful to set high expectations. Be clear on the details of everyone’s roles, including your own. Tell interns to call you right away if a patient takes a turn for the worse. Talk to interns about how to organize and prioritize their days. Ask them about their system and make suggestions to improve it. Help interns understand the “long view” of the goals of the rotation since interns tend to get caught up in the minutia of all the tasks that need to get addressed each day and lose perspective on their general patient care and learning goals. Tell interns the rules about new admissions. (For example, when it is OK for triage to give you new admits, etc.) Be open to suggestions.

3. Work as a group. If you do this and share the work, there will be more time for teaching, (and for much needed breaks). Consider setting goals at the beginning of the day. Help interns manage their time and work more efficiently. Help interns prioritize tasks in the beginning, since everything seems important in the beginning. In the first months, ask the interns how many notes they can write by 10 a.m. and call them at 10 a.m. asking, “Who have you seen and what do you need me to do?” At the end of the day, consider sitting down, going over what we all did today, what do we need to accomplish tomorrow? If you see your intern struggling to get through the patient notes, go over some of the patients and make concrete suggestions that can help the intern be more efficient.

4. Be available and make sure your interns know you are available. Show up when needed. Don’t teach over the phone.

5. Plan for mid-rotation informal feedback and articulate what that feedback will cover. (This feedback session will be something like going to coffee with your intern(s), asking them how things are going, are they accomplishing their stated goals, asking how can we do better, what could I as the resident do differently that will help the team, etc.?)

6. As team leader, you are responsible for the care of patients on your team. This means that you should have a goal of seeing every patient on your team every day! For the sicker patients, you need to spend time and make sure all bases are covered. For the less sick patients, you can spend less time. You should review all patients’ labs every day.

7. Set aside learning time, apart from attending rounds. Every day, pick something from your patient panel: a physical finding, a feature of a patient’s disease that you can explain more fully. These sessions should last just 5-15 minutes. At the beginning of the year, a good teaching session would be “common calls that an intern will get and how to respond to them.” (This session would also be good at the end of the year for the fourth year students.)

8. For specialty rotations, like at the beginning of Medical Intensive Care Unit (MICU), Cardiac (or Coronary) Care Unit (CCU) or oncology rotations, organize a 20-minute team orientation with a Fellow. Make it a short overview of what is expected and perhaps create handouts of essentials unique to that specialty – adjusting vent settings in MICU, interpretation of swan readings and how to make management adjustments based on them, how to respond to a febrile neutropenic patient in oncology, etc.

9. (Repeat!) Occasionally bring coffee for your post call interns or show other concrete signs of support. Periodically check in with your intern to see how he/she is managing emotionally. Your support is reassuring and
helps your interns have a positive attitude.

10. Pay attention to communication with other members of your patient care team. You can work at improving a variety of communications: How to respond to “suggestions” from nursing staff without being confrontational. Listen to nurses and be respectful in talking with them. Don’t get to the point of yelling at a nurse or colleague. Work at being assertive and respectful at the same time.

11. As a sister team resident, you should help your post call intern. Both of your work should be done before you leave the hospital on weekends.
Pre-session: Conviction and Confidence:

How **convinced** are you that it is important for you to be skilled in giving feedback? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **convinced** are you that it is important for you to create an optimal learning environment for your trainees?
*(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **confident** are you that you can give helpful feedback to your trainees? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **confident** are you that you can create an optimal learning environment for your trainees?
*(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10
Post-session: Conviction and Confidence:

How **convinced** are you that it is important for you to be skilled in giving feedback? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **convinced** are you that it is important for you to create an optimal learning environment for your trainees? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **confident** are you that you can give helpful feedback to your trainees? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

How **confident** are you that you can create an optimal learning environment for your trainees? *(0 = not at all; 10 = totally)*

0 1 2 3 4 5 6 7 8 9 10

What skill do you plan to practice in your clinical teaching work in the coming week?

To improve this session, what should I continue doing or do more of? What should I stop doing or do less of?

*If this is your last session, leave enough time for all to offer appreciation for the contributions of everyone in the group. Go around the room and ask each resident the main things they learned out of this series of sessions.*